Appendices

A. Governor Frank O'Bannon's Executive Order

STATE OF INDIANA

EXECUTIVE DEPARTMENT
INDIANAPOLIS

EXECUTIVE ORDER 02-15

FOR: CREATION OF THE COMMISSION ON HOME AND COMMUNITY-BASED SERVICES

TO ALL TO WHOM THESE PRESENTS MAY COME, GREETINGS

Whereas, one of the most important responsibilities of state government is to ensure the health and safety of its most vulnerable citizens, including those citizens under its direct care; and

Whereas, over the last several years, Indiana has moved toward a system of integrated community-based services, and will continue to do so, but institutional care remains an important part of the continuum of state services; and

Whereas, there is a need to address the capacity of community-based services and expand relationships with providers, communities, advocates, and all stakeholders;

Whereas, there is a need to expand strategies that transition the current system of state operated care to community care; and

Whereas, there is a need to develop a comprehensive plan that supports the transition of the current system of state operated care to community care that encompasses previous planning efforts, specifically the work of the Governor's Council on State-operated Care Facilities completed November 30, 2000; and

Now, therefore, I, Frank O'Bannon, by virtue of the authority vested in me as Governor of the State of Indiana, do hereby order that:

1. The Commission on Home and Community-Based Services is created and established;

2. The Commission shall use all relevant state agency resources to complete its work;

3. The Commission shall assess the current capacity of services in the community;

4. The Commission shall identify aspects of current regulations and funding that support institutional care over community care;

5. The Commission shall use all previous efforts focused on increasing community capacity for persons at risk of being institutionalized;

6. The Commission shall work with individual communities, providers, and businesses across the state to address the gap in services in the community, thereby developing a plan to meet the needs for community transition. The plan will consider changes in the types of services provided and the delivery of those services;

7. The Commission shall consist of no more than 21 members, who shall be appointed by and serve at the pleasure of the Governor. The 21 members of the Commission will include four legislators representing both the House of Representatives and the State Senate, as recommended for service by the Speaker of the House and the President Pro Tem of the Senate.

8. The Commission shall submit an interim report in October 2002 and a final report no later than April 2003.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of Indiana on this 9th day of July 2002.

Frank O'Bannon

BY THE GOVERNOR: Frank O'Bannon
Governor of Indiana

Sue Anne Gilroy

ATTEST: Sue Anne Gilroy
Secretary of State

B. Governor's Commission on Home and Community-Based Services Membership Roster

Commission Members, TAG And Technical Support

Chairperson:

Katherine Humphreys

Members of the Governor's Commission on Home and Community Based Services:

Bryan Blanchard
President
Vincennes University

Sally Blankenship
Prosecutor
Ohio and Dearborn Circuit

Billie Breaux
State Senator

Charlie Brown
State Representative

Vincent Caponi
Chief Executive Officer
St. Vincent Hospital

Cleo Duncan
State Representative

Nancy Griffin
State Director
American Association of Retired Persons

Allan Kauffman
Mayor
Goshen, Indiana

Connie Lawson
State Senator

James Leich
President
Indiana Association of Homes
& Services for the Aging

Louis Martinez
President
Lake Area United Way

James McCormick
Assistant Executive Director
Dunn Mental Health Center

Rose Meissner
President
Community Foundation of St. Joseph County

Sharon Pierce
President and Chief Executive Officer
The Villages

Stephen Rappaport, MD
Doctor of Gerontology

Roosevelt Sanders
Minister

William Sheldrake
President and Chief Executive Officer
Indiana Fiscal Policy Institute

Albert Tolbert
Executive Director
Southern Indiana Center for Independent Living

Karen Vaughn
Advocate

Richard Wherry
Parent and Advocate

Technical Advisory Group

Dan Able
Division of Family and Children
Family and Social Services Administration

Alison Becker
Division of Disability, Aging and Rehabilitation Services
Family and Social Services Administration

Doug Beebe
Division of Disability, Aging and Rehabilitation Services
Family and Social Services Administration

Russell Brown
Department of Workforce Development

Amy (Brown) Kruzan
Family and Social Services Administration

Liz Carroll
Indiana State Department of Health

Joan Cochran
Division of Family and Children
Family and Social Services Administration

Richard DeLiberty
Division of Mental Health and Addictions
Family and Social Services Administration

Elizabeth Galvin
Health Evolutions, Inc.

Kimberly Green
Indiana Housing Finance Authority

John Hill
Department of Education

Katherine Humphreys
Commission Chair

SueEllen Jackson-Bonner
Governor's Planning Council

Bill Johnson
Division of Disability, Aging and Rehabilitation Services
Family and Social Services Administration

Steve Johnson
Prosecutor's Council

Venita Kumar
Indiana Department of Transportation

Chuck Martindale
Indiana Department of Commerce

Evelyn Murphy
Office of Medicaid Policy and Planning
Family and Social Services Administration

Chris Newman
Division of Disability, Aging and Rehabilitation Services
Family and Social Services Administration

Tammy Robinson
State Budget Agency

Kenneth Sauer
Commission for Higher Education

Roger Sell
Finance Division
Family and Social Services Administration

Sandra Sleppy
Division of Family and Children
Family and Social Services Administration

Pat Vercauteren
Department of Workforce Development

Nancy Zemaitis
Division of Utilization Review
Family and Social Services Administration

Technical Support:

Judith Becherer
Consultant

Alison Becker
Division of Disability, Aging and Rehabilitation Services,
Family and Social Services Administration

Donna Cameron
Health Evolutions, Inc.

Melissa Dill
Health Evolutions, Inc.

Elizabeth Galvin
Health Evolutions, Inc.

Sanford Garner
A2SO4

Jim Hmurovich
Consultant

Katherine Humphreys
Health Evolutions, Inc.

Tiffany Johnson
A2SO4

Joelyn Malone
Capitol Health Strategies

Mary Jo O'Brien
Capitol Health Strategies

Susan Olds
Health Evolutions, Inc.

Vop Osili
A2SO4

Karen Porter
Health Evolutions, Inc.

Andrea Walsh
Capitol Health Strategies

C. Five Task Forces

Children at Risk Task Force

Task Force Purpose: There are a variety of reasons that children reside in institutions: how the child is initially assessed (or not assessed); incompatible policies of various programs with diverse funding requirements; lack of coordination, communication, or training among states; and community agencies inadequate community support. Community support services cut across a number of state and local jurisdictions including the educational system, judicial system, human services systems, and family and children systems. The purpose of the Children at Risk Task Force is to develop short and long-term strategies for increasing community support services and to encourage integration of services for children who are at risk of being institutionalized into a broad-based spectrum of community services. The Children at Risk Task Force will also identify strategies that serve to prevent the development of risks that could eventually bring about the need for institutionalization.

Function: To examine and report to the Commission on:

- The benefits and limitations of the current system including: how it functions today; how it identifies and processes children; how parents obtain access to the system; how the system is funded; the policies that affect the various components of the system; and areas that should be highlighted because of their success or that need to be strengthened.
- The number of children currently in both public and private residential treatment centers.
- Examination of alternatives to residential care, including a review of how other states have addressed this issue.
- Determination of the barriers that prevent these children from being integrated or reintegrated into a community setting and recommendations for overcoming these barriers.
- Development of a plan that addresses the transitions throughout childhood and adulthood, including the challenges of multi-agency involvement.
- Development of a plan that provides for quality improvement and data to track the outcomes that are important to children and families.
- Develop potential recommendations in a report to be considered by the Commission that summarizes how the focus of the Children at Risk Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Children at Risk Task Force
Chair, Staff, and Members

Chairperson:

Denny Jones
Wishard Hospital

Staff Support:

Jim Hmurovich
Consultant

Members:

Rondle Anderson
Jennifer Asher
David Baker
Debbie Beckman
Sharon Bergman
Betty Bledsoe
Kerry Conway
Jim Dalton
Cathy Duchovic
Mary Edmonds
Tim Elliott
John Ellis
Teresa Hatten
John Hill
Glynn Hipp
Carol Hollinger
Janelle Hudson
Shannon Joerger
Wendy Jones
Drew Klatte
Beth Krouse
Jim McCormick
Janet McIntyre
Beverly Musseter
Shari Paige
Sharon Pierce
Knute Rotto
Lisa Sanders-Adams
Hannah Schertz
Sven Schumacher
Dave Sisk
Sandi Sleppy
Thomas Smith
Cyndy Stancliffe
Jodi Stuck
Rozella Stewart
Jim Vento
Betty Walton
Deborah Washburn

Community Personal Assistance and Support Services Task Force

Task Force Purpose: Many persons could live in their home if they could direct the support provided by a personal caregiver. The purpose of the Community Personal Assistance and Support Services Task Force is to examine the opportunities to expand community capacity and integration for persons at risk of being institutionalized by developing a personal assistance services and support systems model that allows for self-directed care.

Function: To examine and report to the Commission on:

- Innovative and exemplary self-directed care programs in Indiana and other states. The Community Personal Assistance and Support Services Task Force will make recommendations on the opportunities to replicate successful programs.
- Improvement of community-integrated personal assistance with respect to vouchers, provision of services in rural communities, and consumer preparation to transition into the community.
- Expansion of the design and delivery of community-integrated services, specifically as it relates to utilizing the strengths and resources of consumers and families, advocacy programs, alternative family placement/adoption, crisis intervention, and on-going caregiver training and support.
- Expansion of the design and delivery of community-integrated services, specifically as it relates to a fiscal intermediary or employers of record for non-traditional providers, development of provider capacity, refining the approval process, and identifying local solutions to workforce issues, including the use of public-private partnerships to develop fiscal intermediaries, employers of record, and on-going training.
- Develop short and long-term recommendations in a report to be considered by the Commission that -
  summarizes how the focus of the Community Personal Assistance and Support Services Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Community Personal Assistance and Support Services Task Force Chair, Staff, and Members

Chairpersons:

Kathy Davis
Controller
City of Indianapolis

Cris Fulford
Director, Executive and Government Affairs
ATTAIN, Inc.

Staff Support:

Mary Jo O'Brien
Capitol Health Strategies

Members:

Robert Agranoff
Don Baker
Linda Clouse
Elaine Cowen
Richard Daily
Melissa Durr
Deb Euler
Tammy Fish
Nancy Gemmer
Herbert Harris
Christina Helser
Bob Holda
Robert Hughes
Kim Lease
Jean MacDonald
Heather Marcharo
Selena Mault
David Scott
Richard Simers
Linda Simers
Monica Smith
Robert Smith
Jane Vanable
Mark Vinzant
Barb Woods

Housing Task Force

Task Force Purpose: Many individuals live in institutions because of inadequate and unavailable housing both in terms of quantity and quality. The purpose of the Housing Task Force is to coordinate existing resources and develop new housing solutions for persons at risk of being institutionalized.

Function: To examine and report to the Commission on:

- The housing needs of people who are at risk of being institutionalized.
- The alternative housing solutions within Indiana, including a review of how other states have dealt with this issue and what is currently available in Indiana.
- The potential of replicating successful programs through creative funding mechanisms.
- Develop potential recommendations in a report to be considered by the Commission that summarizes how the focus of the Housing Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for legislative and budget resources to support the system's change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Housing Task Force
Chair, Staff, and Members

Chairperson:

John Dickerson
Executive Director
ARC of Indiana

Staff Support:

Melissa Dill
Consultant
Health Evolutions, Inc.

Sanford Garner
A2SO4

Members:

Susan Albers
Bob Adsit
Sally Beckley
Jennifer Hoehm
Bill Boothe
Ron Brackin
Rosie Carney
Alison Cole
Bill Davis
Betty Dragoo
Joe Fahy
Maureen Felkey
Kay Fleck
Laura Frank
Pat Gamble Moore
Sherry Gray
Jim Hammond
Fred Hash
Kimberly Jarrett
James Jones
Deborah McCarty
Tina McIntosh
Linda Muckway
John Niederman
Juli Paini
Francis Sanford
Bill Shaw
Alan Spaulding
Michell Talbert
Mark Williamson

Transitions Task Force

Task Force Purpose: Many individuals are in nursing homes because of an inability to successfully finance and meet their medical needs in alternative, non-institutional settings. Others live in nursing homes because they do not have access to support services that would allow them to stay in their homes or because there is not a range of services to meet their needs. The purpose of the Transitions Task Force is to examine and document the opportunities for increasing community capacity and integration for persons in institutions or at risk of being institutionalized.

Function: To examine and report to the Commission on as follows:

- Estimate the number of people who are potentially at risk for being institutionalized or who could live in a less restrictive environment with a stronger support system.
- Review alternatives to nursing home care, including a review of how other states have dealt with this issue.
- Develop potential recommendations in a report to be considered by the Commission that summarizes how the focus of the Transitions Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Transitions Task Force
Chair, Staff and Members

Chairperson:

Anne Jacoby
Vice President, Vincennes University
Area 16 Agency on Aging/Generations

Staff Support:

Donna Cameron
Consultant
Health Evolutions, Inc.

Members:

Susan Albers
Judith Becherer
Nicki Bradley
John Cardwell
Grace Coulston
Steve Cook
Bob Decker
Kim Dodson
Mark R. Graves
Melissa Durr
Ron Flickinger
Amy Flint
Arlene Franklin
Nancy Griffin
Jaris Hammond
Kristine Harlow
LaDonna Jenson
Bill Johnson
Karen Kissick
Dr. Mary Jane Koch
Faith Laird
Jim Leich
Sonja Long
Jean MacDonald
Steve Metcalf
Evelyn Murphy
Susan Rinne
Katherine Schmitt
David Scott
Paul Severance
Diann Shappell
Georgine Sutkowski
Melissa Van Houten
Jim VanDyke
Mary Louise Wesselman
Dr. David Wilcox
Patricia Wnek
Becky Zaseck

Transportation and Employment Task Force

Purpose: Many people are institutionalized because they do not have basic support systems to allow them to live in the community. Two important critical support services necessary for ensuring successful placement and retention in the community are transportation and employment. The purpose of the Transportation and Employment Task Force is to develop transportation and employment solutions for persons at risk of being institutionalized.

Function: To examine and report to the Commission on:

- Transportation and employment issues of people who are potentially at risk for being institutionalized or who are transitioning from an institutional setting.
- Alternative transportation and employment solutions, including a review of how other states have dealt with this issue and programs that are currently available in Indiana.
- The opportunity to form public-private partnerships with businesses, community teams and activities, and transportation.
- The opportunity to leverage and/or increase the amount of federal funding to support specialized transportation systems and supported employment.
- Creation of community infrastructure to support consumer-directed care, including the development of "best practices," consumer-directed transportation systems, and supported employment.
- Develop recommendations in a report to be considered by the Commission that summarizes how the focus of the Transportation and Employment Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Transportation and Employment Task Force Chair, Staff, and Members

Chairperson:

Curt Wiley
Fannie Mae – Indiana Partnership
Indianapolis, Indiana

Staff Support:

Melissa Dill
Consultant
Health Evolutions, Inc.

Members:

Ronda Ames
Bob Asher
Becky Banks
Dennis Born
Diane Cantrell
Valerie Cook
Jim Hammond
John Hill
Brian Jones
Betsy Kachmar
Dawn Layton
Gail Lee
Kent McDaniel
Steve O'Dore
Susan Preble
Lisa Rector
Pat Rogan
Gail Rubisch-Hawkey
Dorothy Schuerman
Sandra Seanor
Paul Shankland
Karen Swarts
Pat Vercauteren
John Watkins
Diane White
Dan Stewart

D. Consumer Advisory Committee

Consumer Advisory Committee

Purpose: Consumers have not always had support in providing important input in changing needed long-term care service delivery system's change issues. The members of the Consumer Advisory Committee (CAC) will provide serve in an advisory role to the Commission and its Task Forces to ensure that the perspectives and input of each of the target groups are represented appropriately in the recommendations of the Task Forces.

Function: To advise the Commission and five Task Forces and to:

- Provide support for the focus group input, ensuring that all stakeholder groups are represented.
- Develop a list of barriers and suggested solutions related to the systems being addressed by the Task Forces, including the following areas:
  - Nursing Home Transitions
  - Community Personal Assistance Services and Supports (PASS)
  - Children at Risk
  - Transportation and Employment
  - Housing
- Review and comment on all Task Force reports.
- Serve as a resource to the Commission by reviewing the interim and final reports to the Governor.

Consumer Advisory Committee
Chair, Staff, and Members

Chairperson:

Ed Bell
Executive Director
The Independent Living Center
Of Eastern Indiana

Staff Support:

Donna Cameron
Consultant
Health Evolutions, Inc.

Members:

Rosie Carney
Joe Daley
Richard Daley
Abby Flynn
Edna Fulk
Roy Garcia
Nikki Graham
Bob (John) Johnson
Kevin Kilty
Sharon Kozinsky
Veronica Macey
Melissa Madill
Marissa Manlove
Scott Sefton
Suzann Shackleton
David Thomas
Karen Vaughn
Betty Ware
Betty Williams

E. Real Systems Change Mini-Grants

"People helping people help themselves"

Frank O'Bannon, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
John Hamilton, Secretary

NEWS RELEASE

For Immediate Release
February 19, 2003

Contact: Mary Beth Davis
davisMB@fssa.state.in.us (317) 233-4695

Governor's Commission awards mini-grants for community partnerships

Funding directed toward alternatives to institutions for Hoosiers with limited options

INDIANAPOLIS – The Indiana Family and Social Services Administration and the Governor's Commission on Home and Community-Based Care today awarded 12 mini-grants totaling more than $430,000 to expand home and community-based services for the elderly and disabled.

The mini-grants – designed for Hoosiers at risk of being institutionalized or currently in an institution or nursing home -- help people with limited options live as independently as possible in their homes and communities.

Instead of distributing larger grants to a few communities, the Commission is geographically distributing a greater number of smaller grants throughout the state -- up to $40,000 each. The grants are awarded based on whether local proposals encourage innovation in the areas of community living arrangements, housing, transportation, supported employment, and caregiver support.

Grantees in the first round of awards include: a collaborative project with Richmond local government to provide better access to public transportation for the disabled in rural areas; retaining a case manager in South Bend to help with residential treatment for developmentally disabled ex-offenders transitioning back into the community; training and support for consumer directed care providers employed by aged and disabled Medicaid Waiver clients in Bloomington; and training materials for the transitional care of developmentally disabled and mentally ill in Logansport.

The mini-grants are supported by the Real Systems Change Grant, funded by the Centers for Medicare and Medicaid Services. The Governor's Commission aims to maximize the available funds by working with matching and other funding sources in local communities. Only grants that foster collaboration among community partnerships are considered. In fact, all grantees must provide a 10 percent match from a non-federal source, preferably from a community partnership or foundation.

"FSSA is committed to working closely with the Governor's Commission to provide quality services in the least restrictive settings possible," said FSSA Secretary John Hamilton. "The partnerships formed by these grants will help many families see their loved ones still fully participate in the community – and still receive quality care and supervision."

The Commission was created by Governor Frank O'Bannon to develop short and long-term strategies to create or expand community capacity for persons at risk of being institutionalized, or for those currently in an institution or nursing home, within Indiana's long-term care service delivery system. Kathryn Humphreys currently serves as chairperson.

A second round of grants will be awarded in the spring. For more information or mini-grant application materials, visit the Commission's home page at http://www.in.gov/fssa/community

REAL-SYSTEMS CHANGE GRANT RECIPIENTS

GRANT	DOLLAR AMOUNT	SERVED	PREMISE OF PROJECT
Evansville ARC Evansville IN	$40,000	Disabled. Individuals	Premise of this project is to ensure that the day after graduation is the same as the day before graduation for students with disabilities by receiving services from adult services agencies before they exit EVSC. Establish a Transition Coordinator position to work with EVSC school Corp. to ensure day-to-day transitioning for students with disabilities.
The Independent Living Center of Eastern Indiana Richmond, IN	$31,050	Disabled,/Rural areas min of 15 trips a week	ILCEIN will collaborate with government entities to create a consumer designed transportation network in partnership with public transportation services reaching into rural areas. Project will alleviate barriers to inclusive, community-based living lack of transportation and unreliable home health care. Anticipate project will become self-supporting.
Area 10 Agency on Aging Bloomington IN	$40,000	Elderly/disabled Up to 20 individuals for first training	Create a network offering training and ongoing support for consumer directed care providers employed by aged and disabled Medicaid Waiver clients. Will facilitate delivery of services under Medicaid Waiver by streamlining payment process. Will offer state-approved training meeting requirements for attendant care on basic First aid and CPR and instruction on Medicaid Waiver requirements. Once trained, Area 10 will assure that select providers receive regular payment for their services by acting as the fiscal agency for providers and consumers; Area 10 will review for quality of services, accuracy of reporting and consumer/provider relations.
The Villages of Indiana Bloomington IN	$40,000	Foster children/families	Will pilot and refine the direct entry of licensing data into the Indiana Child Welfare Tracking System (ICWIS). Will support DCS's quality licensing consultants by reducing the current 60-90-day processing period to 5 days. The States responsibility for ICWIS data entry for therapeutic foster family licensing will be shared with Indiana's private licensed child placing agencies. The Villages and Children's Bureau will pilot the date entry project and work together to develop an implementation manual for all LCPAs that will include processes and procedures and realistic benchmarks for quality of data entry. This project will eliminate a barrier to services for children in out-of-home placement through a public/private partnership between LCPAs and FSSA.
LifeStream Services, Inc. Yorktown, IN	$34,020	Long term care	Project is aimed at solving significant statewide issues affecting every in-home service provided through the In-Home Services program. Project will use telephone-based automated time and attendance system to increase the efficiency of long-term care system. Significantly change manner in which in-home services are documented, leading to significant savings and increased safety for clients.
LOGAN Community Resources,	$40,000	Ex-offenders	Project called "Criminal Justice Project" will advocate for adults with Dev. Disabilities

Inc. South Bend			who are involved in the criminal justice system. Will retain a case manager to help with areas of education, case management, social supports securing residential treatment during transition into the community.
Adult & Child Care Center, Inc. Indianapolis, IN	$39,639	30 consumers on ACT team	Will employ and train a Peer Support Specialist (PSS) on its existing community-based ACT team who will be an individual who is in recover from mental illness, and has the skills and desire to assist others in recovering. The PSS will receive extensive education and training on illness management and recovery from experienced IMR trainer, Veronica Macy, who is a consumer advocate who owns her own business, Recovery Network unlimited.
A.H. Ismail Center for Health, Exercise and Nutrition at Purdue University Lafayette	$39,835	Elderly	Will train supervisors from Area IV AA and In-Home Services as trainers for Home Support Exercise Program (HSEP) to frail older adults. Case management visits will identify individuals who can benefit for HSEP.
Woodlawn Center Logansport IN	$38,000	Dev. Disabled Mental illness	To develop, produce and distribute three model 15-min. training presentation to be available on video and CD describing the needs of persons with Dev. Dis and mental illness and are in transition to a less restrictive setting.
Indiana Canine Assistant & Adolescent Network, Inc. (ICANN) Indianapolis, Indiana	$21,000	Physically impaired individuals	Will raise and train service dogs to assist persons in Indiana who are living with physical disabilities to achieve greater independence in carrying out activities of daily living. 15 puppies will enter training 5 Dogs will enter advanced training, a minimum of two disabled persons will received ICAAN assistance dogs by April 2004.
Four Rivers Resource Services Linton, IN	$27,981	Disabled individuals needing transportation.	Ride Solution Barrier Removal Project will purchase a small, economical car and pay one year's salary to driver for this vehicle. Provide transportation for people with disabilities.
Rauch, Inc New Albany	$40,000	Blind & visually impaired	Will increase staff expertise through training; provide placement; provide equipment and software specific to the blind and visually impaired. The grant project will allow the development and coordination of a regional/mass training opportunity for a variety of audiences for the filed of serving the blind and visually impaired. Training categories include: etiquette training for personnel who are working with the blind; Assistive Technology for the computer from screen readers to refreshable Braille; office software used with Assistive Technology and workplace strategies in making a site accessible.

MINI-GRANT SECOND ROUND RECOMMENDATIONS

Agency Name	Population(s)	Location	Amount

1. Interfaith Hospitality Network Homeless Families MI Central $31,500
Service to approximately 50 families with a bio-psycho-social assessment, information and referral, case management and clinical services per the individual's family needs. Families with at-risk kids and MI are served.
Mr. Darnae' Scales, Executive Director
520 E. 12th St.
Indpls., IN46202
317-261-1562

2. Key Consumer Organization MI Central $22,027
To promote recovery for consumers with mental illness by providing Wellness Recover Action Plan (WRAP) training to 20 consumers who will use the training to train others. A resource guide to assist persons with mental illness to receive a post secondary education will be developed and shared with the MI population and service providers who work with that population.
Mr. David Thomas, Acting Executive Director
2506 Willowbrook Parkway. Suite 199
Indpls., IN 46205
317-205-2500

3. Indiana Housing Finance Authority DD, MI, Seniors Statewide 35,000
To create methods to permanently fund the Indiana Housing Trust Fund for the purpose of building housing capacity for persons with developmental and physical disabilities, mental illness, and senior citizens.
Ms. Jennifer Boehm, Director
Marketing and Public Affairs
30 South Meridian, 10th floor
Indpls., IN 46204
317-232-7777

4. Independent Residential Living 1st round DD/PD Central $33,300
To develop resources that enable home-owners with disabilities, particularly low to moderate income, elderly and rural persons, to access local services that provide needed home repairs/modifications so that these persons may remain in their own homes.
Mr. Michael Perigo, Resource Development Director
5971 West U.S. 52 #E
New Palestine, IN 46163
877-861-0032

5. Bowen Center, Kosciusko MI NC $24,550
To implement a community policing protocol and standard operating procedure to help meet the needs of mentally ill persons at risk of institutionalization by the establishment of a community coalition team consisting of consumers, families, community leaders, law enforcement, treatment providers, and not-for-profit community agencies. Therefore, when persons with MI interact with law enforcement during a crisis, the protocol can be followed and the risk of incarceration can be decreased.
Mr. Steve Swinehart, Kosciusko County Director
850 North Harrison St.
Warsaw, IN 46580
574-834-1415

6. Indiana Ascn. of Community Economic Development DD/PD Statewide $31,429
To implement a series of training and outreach activities that increase the availability of community based housing to persons with disabilities. 2 specific markets will be targeted: housing suppliers and housing consumers.
Ms. Christie L. Gillespie, Executive Director
324 West Morris Street #104
Indpls., IN 46225
317-423-1070

7. Indiana Chapter of Professional Case Managers Seniors/DD Statewide $31,428

To develop a case management training curriculum modules for professional case managers to be delivered across the state by certified trainers
Ms. Nancy Swaim
IN Chapter of Professional Case Managers
324 W. Morris, Suite #108
Indpls. IN 46225

8. Warsaw Community Schools — DD kids (transition) — NC — $25,342

To develop a vocational program for "at-risk" and disabled students at the Alternative School. Vocational training can assist in transition to work for this population. This Alternative School currently offers only an educational component.
Mr. Tony England, Coordinator of Alternative Services
Warsaw Community Schools
PO Box 288
Warsaw, IN 46581
574-267-3238

9. Wabash Center — DD/MI — NC — $27,921

To obtain overnight support by electronic monitoring from an off-site system that offers a quick response, if needed. Electronic monitoring is much less expensive than overnight staff costs.
Mr. Jeff Darling, President
2200Greenbush Street
PO Box 6449
Lafayette, IN 47903
765-423-5531

10. IARCCA — At-risk kids(SED) — Statewide — $26,075

To develop a comprehensive training program that will educate providers on the Medicaid Rehabilitation Option as a resource for maximizing dollars to support a comprehensive array of services for children and families and promote capacity building.
Ms. Cathleen Graham, Executive Director
5519 E. 82nd, Suite A
Indpls, IN 46250
317-849-8497

11. Center for Behavioral Health — DD including dual diag. — South Central — $31,428

To deliver additional components to the community's continuum designed specifically to meet the needs of adults with dual diagnosis to reduce costly medical visits and to increase autonomy and self-determination
Ms. Stephanie LaFontaine, Developmental Specialist
645 S. Rogers St
Bloomington, IN 47403
812-339-1691

TOTAL **$320,000**

F. Fact Book

Governor's Commission on Home and Community-Based Services

Fact Book

June 19, 2003

TABLE OF CONTENTS

INTRODUCTION

The Commission on Home and Community Based Services exists to pursue actions that will facilitate immediate and lasting change in the delivery of long-term care services in Indiana. The Commission's work is targeted to persons who are or may become dependent upon long-term care services. The Commission will recommend actions based upon a public policy that makes sense, is financially accountable, and promotes personal choice by the persons receiving, or at risk of receiving, long-term care services. The Commission will build upon the good work already accomplished by other commissions and groups and will be guided by activities and implementation strategies that improve the lives of people currently affected by these services. Each recommended action is intended to help overcome the well-known systemic barriers, current policies and procedures, and organizational practices that are obstacles to change.

ACKNOWLEDGMENTS

This report represents the culmination of several months of conceptualizing, data collection, and analysis. It could not have happened without the leadership of Katie Humphreys, and the support of Elizabeth Galvin, Katie Howard, Richard Deliberty, Tammy Robinson, Celia Leaird, Seth Frotman (Indiana University Law Student), Roger Sell, Wanda Williams, and the dedicated staff of the Family and Social Services Administration and Health Evolutions. We hope that the report contributes to policy decisions that will improve the lives and opportunities of those receiving, or at risk of receiving, long-term care services in Indiana.

SECTION I: THE POPULATIONS

Indiana's population by age group as compared to the United States population by age is demonstrated below.

Population Facts

	Indiana	USA
Population, 2001 estimate	6,114,745	284,796,887
Population, 2000	6,080,485	281,421,906
Population, percent change, 1990 to 2000	9.7%	13.1%
Persons under 5 years old, percent, 2000	7.0%	6.8%
Persons under 18 years old, percent, 2000	25.9%	25.7%
Persons over 18 years old and under 65	54.7%	55.1%
Persons 65 years old and over, percent, 2000	12.4%	12.4%
Persons at or below federal poverty levels, 2000	9.5%	12.4%

Source: iii

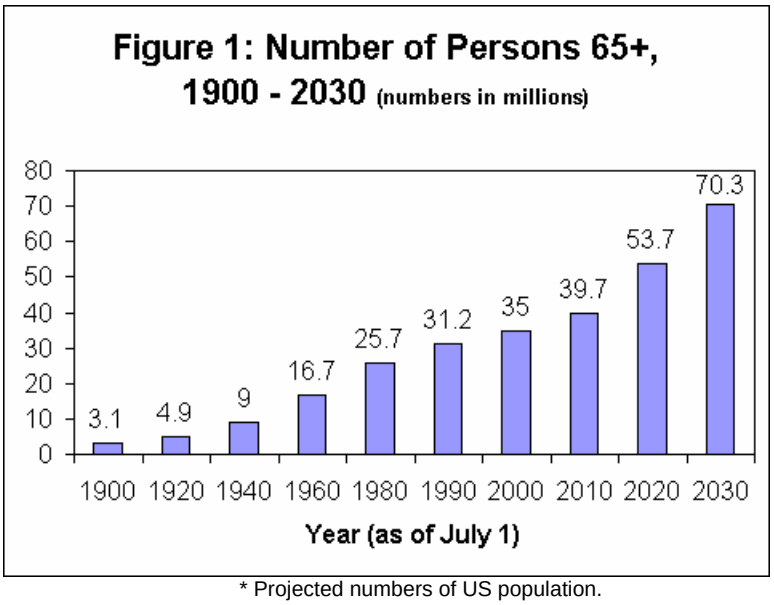
What Populations have the Task Forces Reviewed?

The Task Forces have looked at demographics and services for

- The elderly (age 65 and older)
- Persons with Developmental Disabilities
- Persons with mental illness
- Persons with physical disabilities
- Children who are at-risk

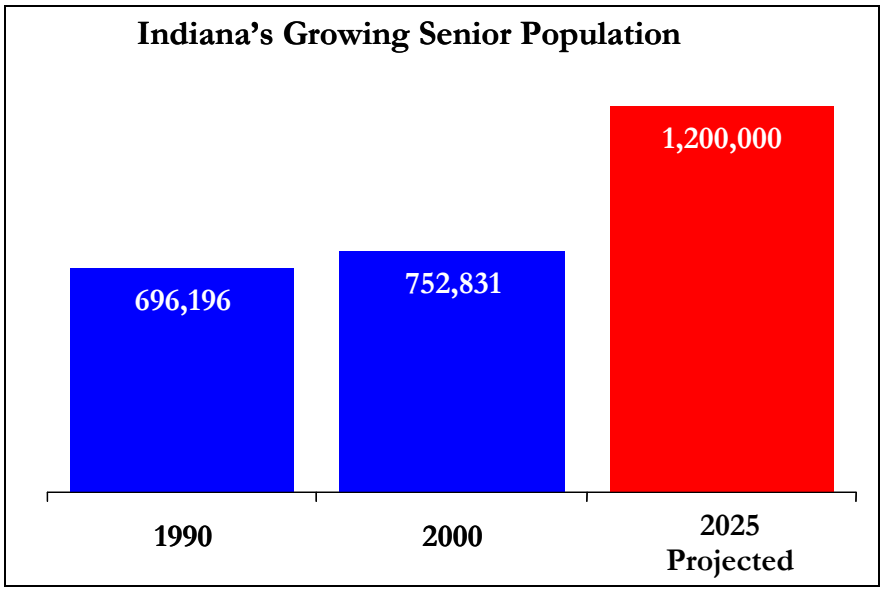
1. ***The Elderly***

"Seniors" are defined as persons who are age 65 or older. Population trends show that this segment of the population is growing rapidly. The 2000 U.S. Census counted 35 million people who are age 65 or older, a 12% increase from the 1990 census. It is estimated that the number of seniors will double by 2030. That estimate translates into 70 million seniors, representing 20% of the American population. In other words, one out of every five persons will be age 65 or older. Since the disabled are a large segment of the US population and disability often accompanies the aging process, clearly, the percentage of seniors nationwide with disabilities would be expected to increase proportionately. Estimates show that disabled seniors will account for 27% of the elderly population by the year 2020.



* Projected numbers of US population.

According to 2000 census figures, 12.4% of Indiana's population was 65 or older.[i] This translates into more than 752,000 persons, or one in every eight Hoosiers. According to data compiled by the Federal Administration on Aging, the senior population in Indiana increased by over 8% from the 1990 census.[ii] By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million, making it the second-largest age category in the state with ratios mirroring the national estimates of nearly 20% of all Americans. For Indiana, however, this represents nearly a 60% increase from just the 2000 census figures over the next 25 years.



- **How many seniors are in need of care?**

Within this population group, it is estimated that at least 60 percent of people 75 and older will require some form of long-term care during the remainder of their life. In 2001, over 40,000 Hoosier seniors received care in a nursing home facility. Medicaid-eligible residents accounted for 2/3 of nursing home beds at a total cost to the taxpayers of $813 million. Although Indiana's 1999 nursing home bed ratio dramatically exceeded the national average at 83.8 beds per thousand seniors, (compared to a national average of 52.3), overall payments to nursing facilities decreased by 2.4% from 1995 to 2000.

Of Medicaid long-term care beneficiaries receiving services in 2000, approximately 75% received care in a nursing home, ICF/MR, or group home, while only 7.1% received long-term services through Medicaid waiver programs.

Medicare Enrollment *

As of July 1, 2001

	Total Population	Medicare -- All Beneficiaries		Disabled Beneficiaries		Aged Beneficiaries	
		Enrolled	%	Enrolled	%	Enrolled	%
United States	284,796,887	39,149,152	13.7%	5,405,700	1.9%	33,743,452	11.8%
Indiana	6,114,745	858,150	14.0%	120,335	2.0%	737,815	12.1%

* Enrollment is defined here as having coverage through Medicare Part A and/or Medicare Part B Supplemental.

How many seniors are below the Federal Poverty Limit (FPL)?

In 2001, national figures show that about 3.4 million elderly persons (10.1%) were below the FPL. These figures remained relatively constant after reaching a historic low in 1999. Another 2.2 million or 6.5% of the elderly were classified as "near-poor" with an income between the poverty level and 125% of this level.

According to data compiled by the Federal Administration on Aging which is calculated on the basis of the official poverty definitions for the years 1999-2001, nearly 8 percent of Indiana seniors aged 65 and older fall below the federal poverty level.[iii] Approximately 70,000 Hoosier seniors have monthly incomes less than $738 and annual incomes less than $8,860. This is somewhat lower than the national average of 9.9 percent.

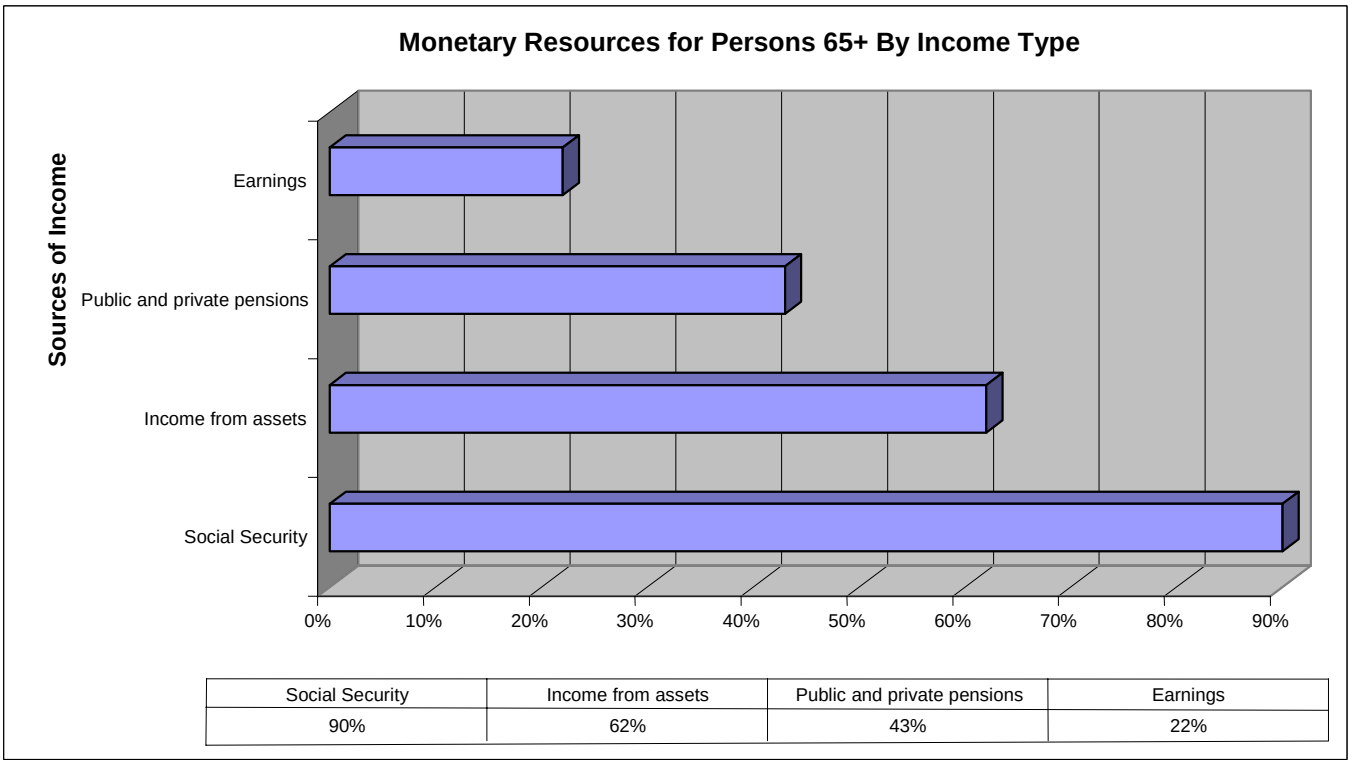
The federal poverty guidelines are calculated according to the following guidelines:

2002 HHS Poverty Guidelines	
Size of Family Unit	Contiguous States and D.C.
1	$8,860
2	11,940
3	15,020
4	18,100
5	21,180
6	24,260
7	27,340
8	34,420
For each additional person, add $3,080	

- **What is the major source of income for seniors?**

The Social Service Administration reported that the major sources of income for seniors in 2000 were the following:

- Social Security
- Income from assets
- Public and private pensions
- Earnings[iv]



Social Security	Income from assets	Public and private pensions	Earnings
90%	62%	43%	22%

2. ***Adults and Children with Developmental Disabilities***

- **Who are the Adults and Children with Developmental Disabilities?**

Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment (other than the sole diagnosis of mental illness), which manifest before age 22 and are likely to continue indefinitely. They result in substantial limitations in three or more of the following areas:

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency

Nearly four million Americans can be classified as developmentally disabled (MR/DD.) Approximately 3 percent (182,000) of Indiana's population have a developmental disability.[v] Indiana has 1,800 people with Developmental Disabilities living in a nursing home environment. Only four states have more.

In SFY 2000, of Indiana's 23,431 Medicaid enrollees with developmental disabilities and mental retardation, slightly more than 2% were served in state-operated facilities; 4 percent received care in ICF/MRs; and over 16% were served in a group home environment. The number of facility residents declined by nearly 50% in SFY 2000.

The numbers of MR/DD individuals currently receiving services identified by program areas are:

Service Setting	Clients	% of Total
Nursing Homes	4,396	33.5%
Group Homes	3,795	29.0%
Individuals on Individual Community Living Budgets (100% State funds)	3,315	25.3%
Large, Private ICFs/MR (11 Facilities)	832	6.3%
State Developmental Centers	608	4.6%
State Hospitals	160	1.2%
	13,106	**100.0%**

3. ***Adults and Children Who Are Mentally Ill***

- **Who are the Adults and Children who have mental illness?**

Mental illness is defined as those 18 years of age or older with a diagnosis of a major mental illness, severe disability, and no required duration (including those who have intermittent periods of serious mental illness over a long period of time.)

A serious emotional disturbance (SED) is defined as those under 18 years of age with a condition that results in improper behavior that interferes with the individual's ability to learn and function under normal circumstances. Children and adolescents with a SED have mental health problems that severely disrupt daily life at home, at school, and in the community.

Individuals with a serious mental illness often face insurmountable hurdles when attempting to enter the workforce. Some have educational gaps, concentration or endurance problems, and/or have medication-related side effects that make working difficult. There is an extremely high unemployment level among persons with mental illness, reaching as high as 85%.[vi]

Of the 44 million Americans who experience a mental disorder each year, nearly 1/3 are children.[vii] One in every five families is affected by a severe mental illness, such as bipolar disorder, schizophrenia, or major depression at some point. One in five American children and adolescents experience a behavioral, emotional, or mental health problem. One of every ten children or adolescent has mental illnesses severe enough to cause some level of impairment. Yet less than 20% of these young people ever receive needed treatment. [viii]

In Indiana, an estimated 270,000 adults (6% of the adult population) suffer from some form of mental illness.[ix] An additional 80,000 Hoosier children, ages 9 to 17, suffer from serious emotional disturbances**.** It is estimated that 223,000 Hoosiers have at least one co-occurring mental health and substance abuse disorder. The data also indicates that the severity of emotional and behavioral problems among adolescents is associated with increased likelihood of substance abuse. [x]

4. ***Adults and Children with Physical Disabilities***

Data regarding the disabled population is more limited than for other groups. Such is reflected in the following excerpts of a 1995 Department of Health & Human Services study [xi]. The survey cites several reasons for the lack of good data:

> While much is known about the frail elderly and their use of services, relatively little is known about other groups of persons with disabilities such as children, working age adults, and special populations (e.g., mentally ill, developmentally disabled) that cut across age groups.
>
> Numerous Federal surveys collect disability data on the working age population (aged 18-64), but except for the 1994/95 Disability Survey, none focus primarily on disability. That was not always the case. SSA conducted the Surveys of Disability and Work every few years beginning in the early 1960s in order to measure the extent of disability in the working age population and to examine the experience of disabled workers on SSDI and their families. The last Survey of Disability and Work was conducted in 1978 and there are no plans to repeat the survey. Nowadays, data sources include either special surveys on disability (like the 1994/95 Disability Survey) or the addition of disability questions on non-disability surveys.
>
> There are crucial but unresolved definitional and measurement issues among the working age population. No equivalent severity measures and survey questions have been developed for physical versus mental impairments. The standard functioning questions based on ADLs and IADLs often break down.
>
> A small but important segment of the working age population with disabilities are institutionalized (i.e., nursing homes, mental hospitals, prisons) or are homeless. Since few national surveys include this population and since the few surveys which focus on the institutionalized (i.e., the National Nursing Home Survey) have very small samples of the non-elderly, we know little about this group.

Disability Status of the Civilian Non-Institutional Population

	Indiana		U.S.	
	Number	**%**	**Number**	**%**
Population 5 years and over	**5,563,619**		**257,167,527**	
With a disability	1,054,757	19.0%	49,746,248	19.3%
Population 5 to 15 years	**972,185**		**45,133,667**	
With a disability	61,622	6.3%	2,614,919	5.8%
Sensory	9,746	1.0%	442,894	1.0%
Physical	9,891	1.0%	455,461	1.0%
Mental	50,918	5.2%	2,078,502	4.6%
Self-care	8,306	0.9%	419,018	0.9%
Population 16 to 64 years	**3,884,065**		**178,687,234**	
With a disability	691,505	17.8%	33,153,211	18.6%
Sensory	97,418	2.5%	4,123,902	2.3%
Physical	243,669	6.3%	11,150,365	6.2%
Mental	144,016	3.7%	6,764,439	3.8%
Self-care	63,617	1.6%	3,149,875	1.8%
Going outside the home	204,264	5.3%	11,414,508	6.4%
Employment disability	439,868	11.3%	21,287,570	11.9%
Population 65 years and over	**707,369**		**33,346,626**	
With a disability	301,630	42.6%	13,978,118	41.9%
Sensory	105,274	14.9%	4,738,479	14.2%
Physical	209,251	29.6%	9,545,680	28.6%
Mental	70,735	10.0%	3,592,912	10.8%
Self-care	64,661	9.1%	3,183,840	9.5%
Going outside the home	138,302	19.6%	6,795,517	20.4%
Population 18 to 34 years	**1,419,258**		**64,654,308**	
With a disability	191,349	13.5%	9,468,241	14.6%
Percent enrolled in college or graduate school		12.8%		14.5%
Percent not enrolled and with a bachelor's degree or higher		6.0%		7.9%
No disability	1,227,909	86.5%	55,186,067	85.4%
Percent enrolled in college or graduate school		21.0%		21.4%
Percent not enrolled and with a bachelor's degree or higher		14.4%		17.5%
Population 21 to 64 years	**3,434,336**		**159,131,544**	
With a disability	635,620	18.5%	30,553,796	19.2%
Percent employed		60.8%		56.6%
No disability	2,798,716	81.5%	128,577,748	80.8%
Percent employed		80.2%		77.2%

Source: U.S. Census Bureau, Census 2000 Summary File 3, Matrices P42, PCT26, PCT27, PCT28, PCT29, PCT30, PCT31, PCT32, and PCT33.

5. ***Children At-Risk***

- **Who are Children At-Risk?**

Approximately 26% (1.58 million) of Indiana's population are children 17 and younger.[xii] The Annie E. Casey Foundation defines the "at risk child" as a child who lives in a family with four or more of the following risk factors:[xiii]

- The child does not live with two parents;
- The head of household is a high school dropout;
- The family income is below poverty level;
- The child lives with underemployed parent(s);
- The family receives welfare benefits;
- The child does not have health insurance.

The Indiana Children At-Risk Task Force has identified additional indicators of children who may be at-risk.

Pre-natal at-risk indicators include:

- Smoking
- Alcohol and drug use
- Lack of health care visits in the first trimester
- Nutrition/diet quality/food insecurity
- Pregnancies too close together
- Teen pregnancy and unmarried teen pregnancy Low birth weight
- Housing instability and/or employment instability

Children who may be at risk are:

- Children in TANF families
- Children in Food Stamp families
- Children receiving free and reduced school breakfast and lunch programs
- Baby born to a mother under 20 with no high school degree
- Children whose sibling is arrested
- Children in a low family functioning
- Children whose sibling is a victim of abuse/neglect
- Children who experience stress in the social environment
- Children whose parents are separated, or whose parents are separated from them
- Children who have not bonded with parent(s)
- Children whose family experiences economic stress
- Children whose families have lost insurance
- Children whose families have insurance that does not cover a specific condition
- Children whose families have insurance with high co-pays
- Children with a lack of access to health care
- Children with a criminal arrest in the family
- Children with a parent who is incarcerated
- Children who live in neighborhoods with crime, gangs, and drugs
- Children whose parent(s) abuse drugs and alcohol
- Children of parents with serious mental illness or developmental disabilities
- Children with autism or serious emotional disorder

Children who are at imminent risk are:

- Victim(s) of abuse, neglect, or other crime
- Children who are truant and/or experience academic failure
- Children who commit delinquent acts
- Children who use drugs or alcohol
- Children who experience family economic stress
- Children who commit a parole or probation violation
- Children who age out of the foster care system

Children who are in risk are:

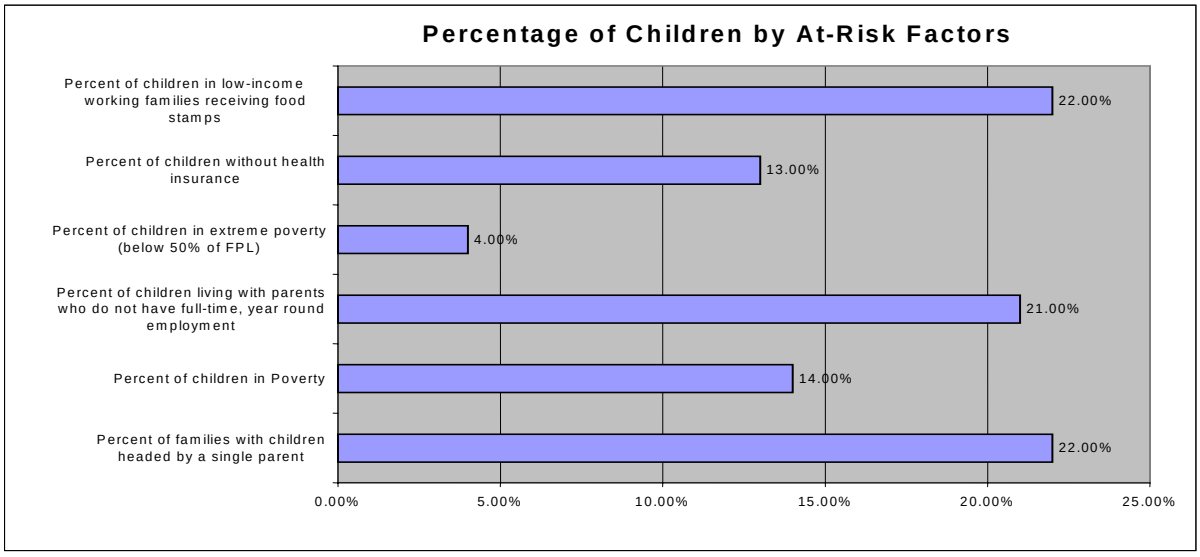
- Children in state-operated facilities
- Children who are committed to the Department of Correction
- Children in-patients in private hospitals with private pay
- Children in private detention and treatment centers
- Parole violators

It is pertinent to note that the number of risk factors is more predictive of "at risk" results than any one factor by itself or any combination of several factors.

2000 census data indicates that 11% (174,000) of Hoosier children live in poverty, compared with 16 % nationally, showing that Indiana fares better than many other states.

Nationally, 12% of all children could be classified as at-risk, a decrease of 1% from 1990. The table below reflects the occurrence of risk factors for children in the U.S.

According to data collected by the Annie E. Casey Foundation, 6% (95,000) of Hoosier children are at-risk.[xiv] Indiana decreased its number of at-risk children by half (12%-6%), marking the second largest improvement of any state during the years 1990-2000.



In addition to at-risk factors, the Children At-Risk Task Force identifies the following child well-being factors:

Children living in financial security
Children living in stable and secure housing situations
Children who have health care
Children who receive nutrition/diet quality/food security
Children whose immunizations are current
Children who have had well-baby visits
Children whose parents/families read to them
Children who receive affordable and quality childcare

It would be the desire of this commission to develop a web-site that links all the available data regarding at risk children in Indiana. This data should be organized by county.

SECTION II: SERVICES

This section seeks to define the services vital to the populations described in Section I. National and state data is included where possible.

1. ***Housing***

Of the 21.8 million households headed by older persons in 2001, 80% were homeowners while the remainder were renters. The median family income of older homeowners was $23,409 but only $12,233 for older renters. In 2001, 41% of older householders spent more than one-fourth of their income on housing costs, compared to 39% of for homeowners of all ages.

Nationally, there are 6.1 million very low to extremely low-income seniors with priority housing problems. It would take over 40,000 additional housing units a year just to maintain the current ratio of six seniors with unmet housing needs to each subsidized unit now occupied by a senior. It is estimated that there will be 9.5 million low to extremely low-income seniors in 2020. Assuming that only one-quarter of those seniors want to live in rent-assisted housing, it would be necessary to provide 140,000 units a year for the next 17 years.[xv]

According to the 2000 US Census, there are more than 2.5 million housing units in Indiana. About 196,000 were vacant and 71% of the housing units are owner-occupied. Affordable housing is an essential component of family and personal well-being; however, locating affordable housing may be easier said than done for a large part of Indiana's special populations. Over 28% of renters spend more than 35% of their income for rent alone. In Indiana, a full-time worker must earn $10.93 per hour to rent a modest two-bedroom home.

2. ***Transportation***

The inability to access affordable, reliable, and convenient transportation contributes to job loss and low job retention.[xvi] However, accessible transportation also impacts several other quality of life indicators such as political participation, access to entertainment, socialization, and religious attendance. Without transportation, Hoosier families are negatively impacted in most means that maintain self-sufficiency.

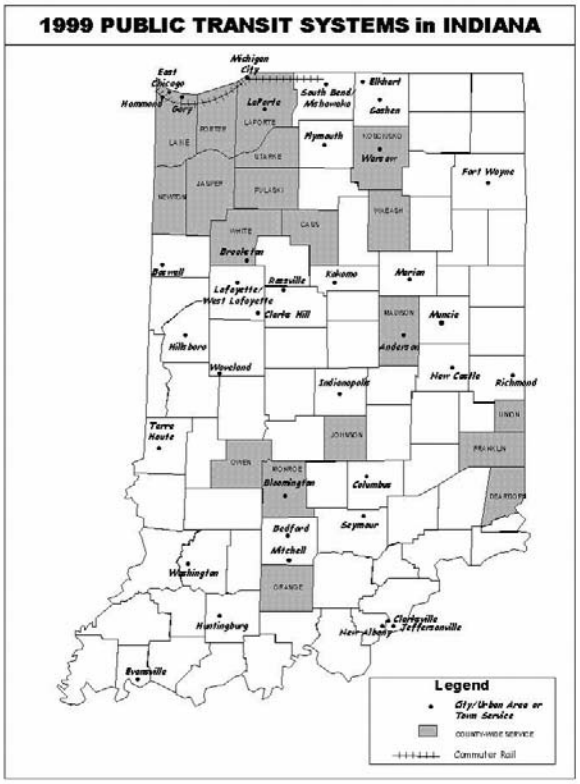
For the elderly and disabled population, the lack of available and convenient transportation can exacerbate isolation, as well as negatively impact their ability to access work opportunities, health

care, groceries, and other essential services. Medicaid-eligible individuals can access transportation through program covered health care services only.

In the year 2000, inaccessible and unavailable transportation remained an obstacle confronting persons with disabilities, hindering their ability to work and socialize outside the home. For every 10 disabled persons, 3 will have problems accessing adequate transportation. By contrast, only 1 out of 10 people without a disability have a problem with adequate transportation and of those experiencing difficulty, only 4% cite transportation as a major problem. The transportation gap between people with disabilities and people without disabilities has actually widened by 7 percentage points since 1998.[xvii]

Not surprisingly, inadequate transportation is an even greater obstacle for people with severe disabilities. People with a somewhat severe to very severe disability are more than three times as likely to view transportation as a problem (34% and 36% respectively) than people without disabilities (10%.)[xvii]

Income also seems to play a large role as people with annual household incomes of $15,000 or less, regardless of whether or not they are disabled, are much more likely to say transportation is a problem than people with annual household incomes of $50,000 or more. [xvii] Although Indiana has 44 public transit systems, 29 counties have no public transportation providers. [xvii]



3. ***Vocational Services***

People with disabilities are employed at lower rates that the general population. Moreover, the more severe the disability, the less likely a person is to be employed. The National Organization on Disability reports that only 32% of Americans with disabilities aged 18 to 64 are working compared to 81% of those without disabilities in this age category.[xviii] Two-thirds stated that they would rather be working.

Of those who reported encountering barriers, approximately 35% indicated that they could not afford training or educational programs or that they had been denied entrance into the programs. Only 9% replied that they faced discriminatory attitudes on the part of training staff.[xix]

According to Census 2000, more than 140,000 Indiana civilian non-institutionalized persons age 16 to 64 had an employment disability and were unemployed.[xx]

4. Community and Personal Assistance Support Services

The populations addressed within this data book obtain their health and personal assistance support services predominately through Medicaid funded programs. Although Medicaid eligibility standards are quite complex, in general it can said that eligibility requirements for Medicaid sponsored programs are as follows:

Members of Families with Children. Families meeting the income and resource standards for the Temporary Assistance to Needy Families (TANF) program are also eligible for Medicaid whether or not they actually receive TANF cash assistance.

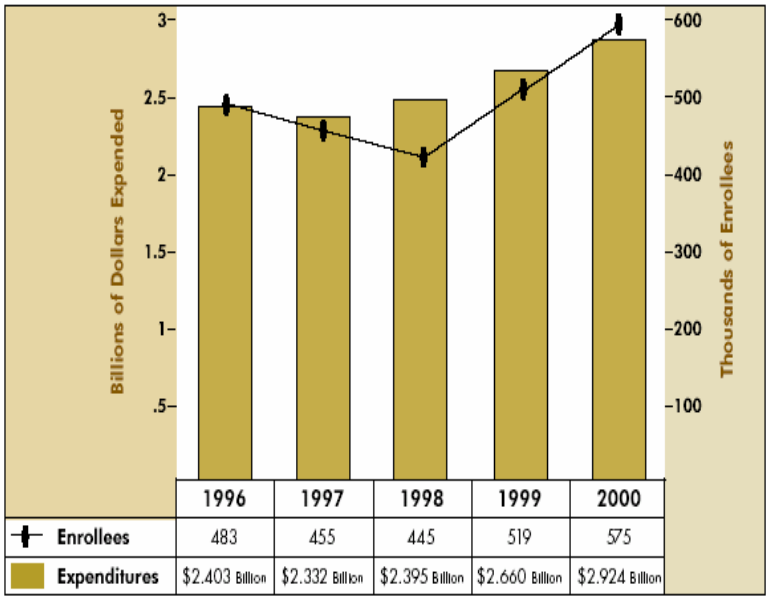
Children and Pregnant Women Pregnant women and children under age nineteen with family incomes up to 150% of the federal poverty level are eligible for Medicaid. Prior to July 1, 1998, children from age one through age five were not eligible if their family incomes exceeded 133% of the federal poverty level and children aged 6 through 18 were not eligible if their family incomes exceeded 100% of the federal poverty level. The income standard and continuous coverage were adopted by the Indiana General Assembly in Public law 58-1998 which is “Phase I” of Indiana’s implementation of the federal Children’s Health Insurance Program.

Aged. Individuals aged sixty-five or older are eligible for Medicaid if they meet certain financial criteria. The financial criteria are more lenient if one spouse is in a nursing facility, while the other lives in the community. In addition, persons eligible for Medicare Part A may qualify to have Medicaid pay their Medicare premiums, co-payments and deductibles as a Qualified Medicare Beneficiary (QMB), a Qualifying Individual (QI), a Qualified Disabled and Working Individual, or a Specified Low Income Medicare Beneficiary (SLMB).

Blind and Disabled. The definition of “blind” for eligibility purposes is the same as the definition used by the federal Social Security Administration. To be eligible in the disability category, a disabled person must have a physical or mental impairment, disease or loss that appears reasonably certain to continue throughout four or more years of the individual’s life without significant improvement. The disability must also substantially impair his/her ability to perform labor or to engage in a useful occupation. Blind and disabled recipients may also be eligible for the Medicare-related programs described above, if they are eligible for Medicare.

The Medicaid program has grown substantially on a national and state level. The growth of the Indiana's Medicaid program is reflected in the increase in enrollees and expenditures:

Medicaid Enrollees and Expenditures[7,8,9] [Figure 1]



	1996	1997	1998	1999	2000
Enrollees	483	455	445	519	575
Expenditures	$2.403 Billion	$2.332 Billion	$2.395 Billion	$2.660 Billion	$2.924 Billion

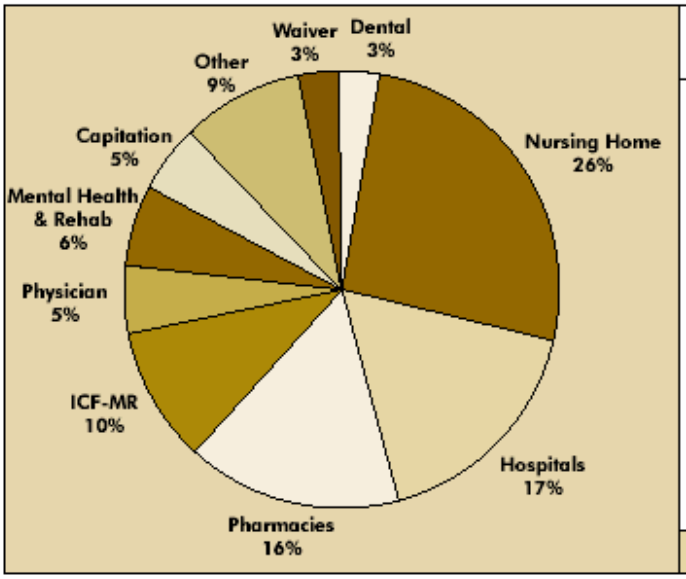
The increase in expenditures is closely related to the growth in services provided in institutional settings such as nursing homes and hospital. This trend is directly related to the growth of the population over the age of 85.

Although the aged, blind and disabled population accounts for only 25% of all Medicaid beneficiaries, they also account for 68.8% of all Medicaid-related spending during State Fiscal Year 2001. Conversely, low-income families that comprise 75% of the Medicaid-eligible population, actually, only account for 31.2% of all Medicaid expenditures. This is due to the fact that the aged, blind, and disabled categories utilize health-care services more intensely than the low-income segment of the Medicaid-eligible population.

Payments by aid group for SFY 2001 are indicated below:

Aid Group	Total Payments	% of Total Payments
Disabled	$1,210,316,030	37.2%
Aged	$1,000,948,966	30.8%
Child	$577,352,418	17.7%
Adult	$206,437,412	6.3%
Pregnant Women	$90,301,047	2.8%
CHIP I	$75,775,573	2.3%
Uncategorized	$58,389,807	1.8%
Blind	$26,019,796	0.8%
CHIP II	$7,565,864	0.2%
Total	**$3,253,106,913**	**100.0%**

Medicaid Expenditures by Provider Category [Figure 2]



Provider Category	Expenditures (in Millions)
Nursing Home	$ 773
Hospitals	498
Pharmacies	454
ICF-MR	289
Physician	156
Mental Health & Rehab	164
Capitation	145
Waiver	101
Dental	88
Other	256
Total	**$2,924**

Traditionally, the majority of older and disabled adults have lived in nursing homes and state supported institutions, many because no other alternatives have been available to them. Consumer preferences, the high cost of institutional care, and recent Supreme Court rulings (*L.C. & E.W. vs. Olmstead*) have slowly eroded such care restrictions. In an effort to assist seniors and persons with

disabilities in maintaining their independence and privacy, several in-home and community-based personal assistance support services have been incorporate as alternatives to institutionalization.

Community-based care originated as an outgrowth of the idea of meeting the needs of people with disabilities by emphasizing a presence in the community, health and safety, and self-determination. These programs provide high quality, cost effective, and accessible services that afford older persons and persons with disabilities the ability to maintain their independence and privacy by preserving the option to live independently in their own homes as long as possible. In-home services include home health services, homemaker services, attendant care, respite care, adult day services, transportation, home delivered meals, habilitation, therapies, as well as other appropriate services such as minor home modifications and adaptive aids. All of these services are available, including Medicaid waivers, through a case management driven system.

At present, it is estimated that more than 291,000 Hoosiers over age 65 experience some limitation in two or more "activities in daily living" such as bathing, dressing, or walking, and an additional 559,000 Hoosiers below age 65 who experience some limitations in these activities.[xxi]

5. *Institutional Services vs. Community Services*

The number of Hoosiers with disabilities and mental illnesses that are receiving home-based services or in services within the community has more than doubled while the number in a state-owned or private institution has been cut in half.

Although the predominate focus of community-based services rests on maximizing quality of life, there is no dispute that the cost of institutional care is higher than the cost of services provided in a community-based setting. One nationwide study calculated the cost of institutional care as more than six times the average cost of community-based care.

Indiana Nursing Home Facts

Average Medicaid Daily Rate	$102.08
Average Private Pay Daily Rate	$120.58
Number of Medicare Certified Beds	3,258
Number of Medicaid Certified Beds	14,421
Number of Dual Medicare/Medicaid Certified Beds	37,786
Number of Medicaid Home Health Agencies	140

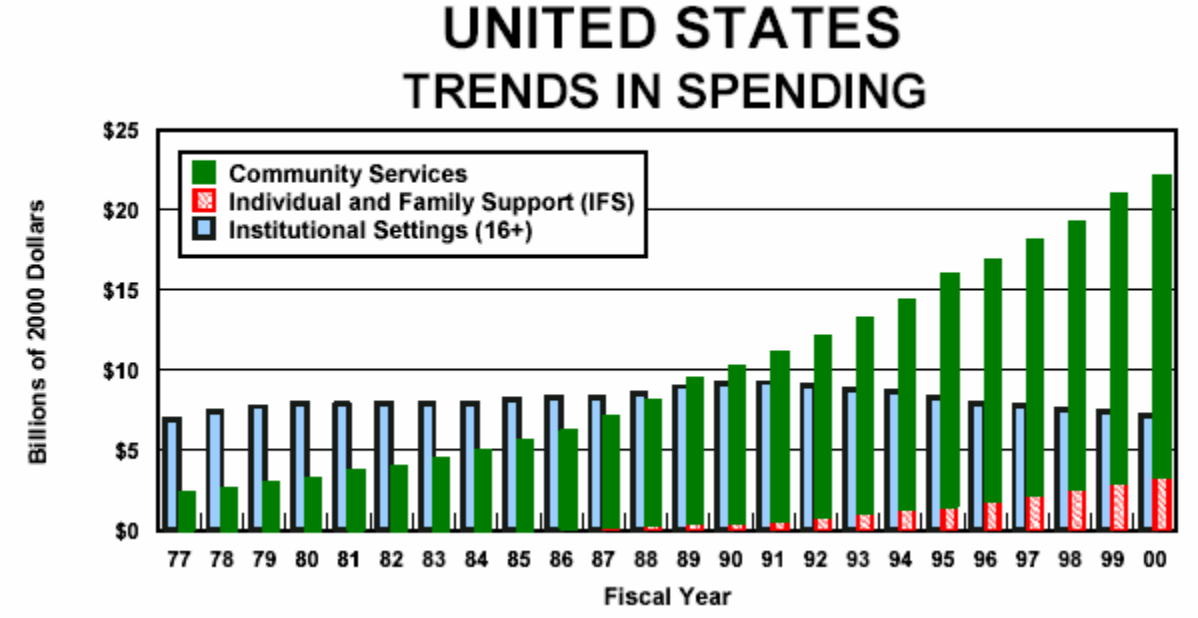
In-Home vs. Institutional Cost

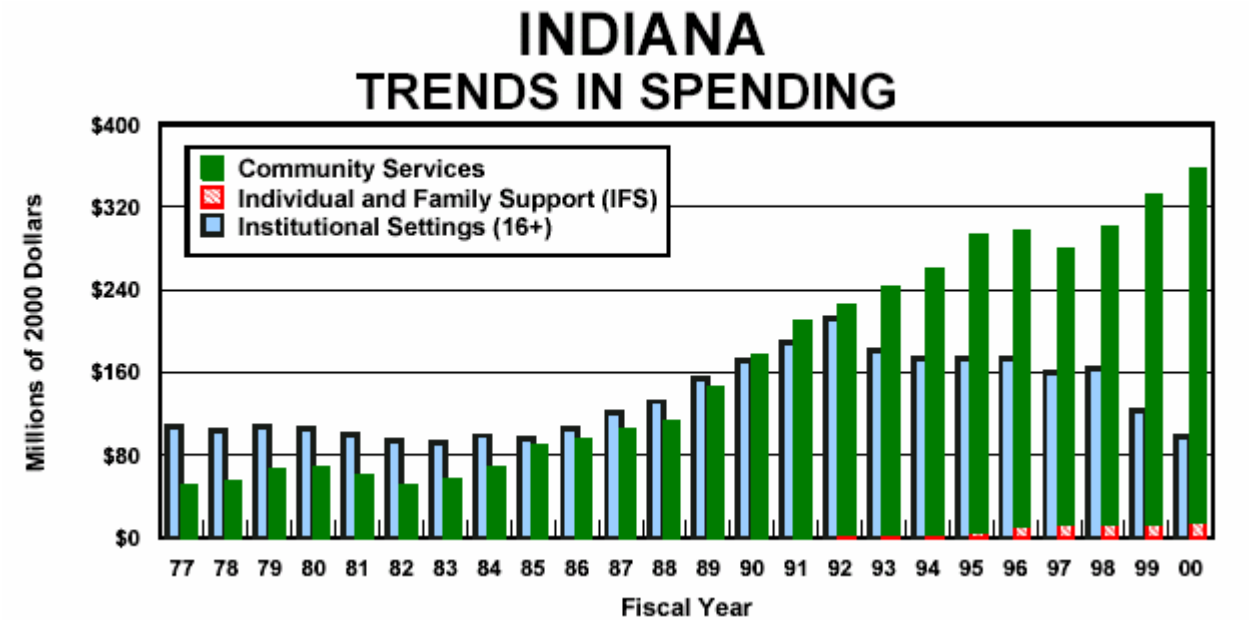
Average CHOICE and Aged and Disabled Medicaid Waiver Costs Compared to Medicaid Nursing Facility Case Mix Average Rate*

	Average CHOICE Cost	Average A&D Waiver Cost	Nursing Facility Case Mix Average Rate
DAILY	**Total**		
State Share	$19.82	$10.58	$38.20
Federal Share	-0-	$17.30	$ 62.42
TOTAL	$19.82	$27.88	$100.62
MONTHLY			
State Share	$602.86	$321.93	$1,161.92
Federal Share	-0-	$526.15	$1,898.61
TOTAL	$602.86	$848.08	$3,060.53
ANNUALLY			
State Share	$7,234.30	$3,863.17	$13,941.30
Federal Share	-0-	$6,313.79	$22,785.00
TOTAL	$7,234.30	$10,176.96	$36,726.30

One rather dramatic example is the Muscatatuck State Development Center in Butlerville, Indiana, a state-owned institution that cares for its 177 residents on an annual operating budget of $56 million. These figures translate into a staggering cost of approximately $316,000 per person per year.

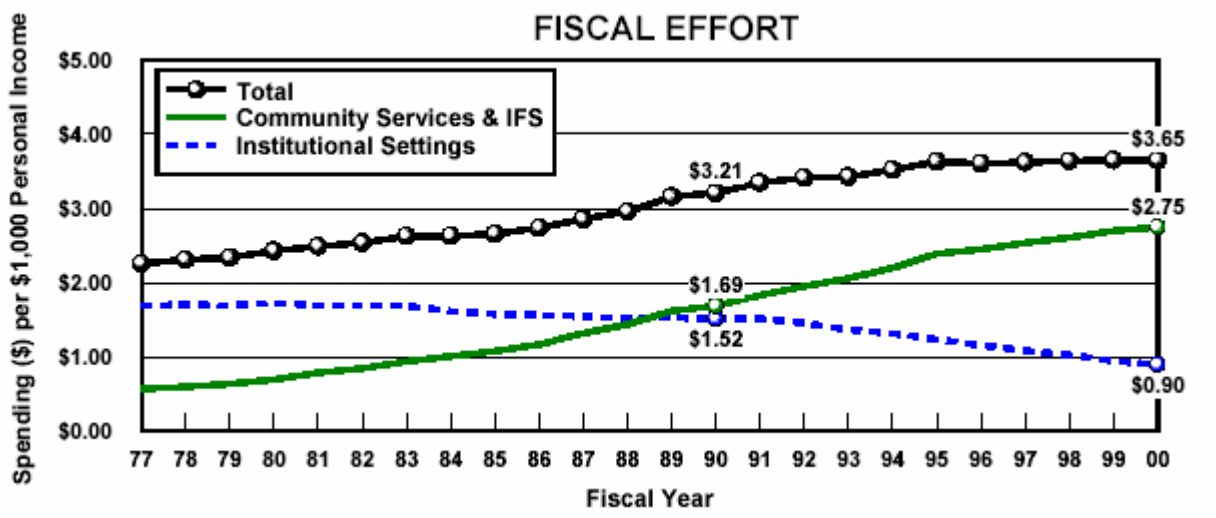
The next page of charts provides a comparison of programs as well as spending and funding sources for developmental disability programs across the United States.



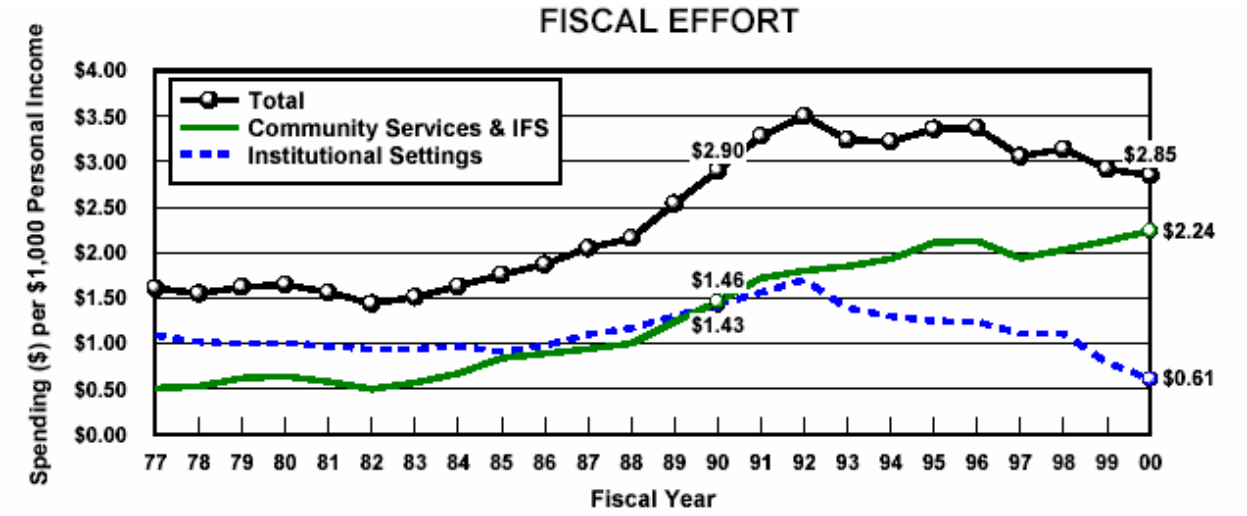


Indiana's shift in funding from institutional settings to community base services has been more dramatic than the national average. As reflected above, Indiana has increased spending for home and community-based services by 620% since 1982. Over the same period, the U.S. as a whole has increased spending for home and community-based services by only about 390%. Beginning in 1992, Indiana's funding for institutional settings began to decrease. From 1992 to 2000, the state reduced funding for institutional settings by 52%. For all states, the reduction over this period was only 16%.

UNITED STATES

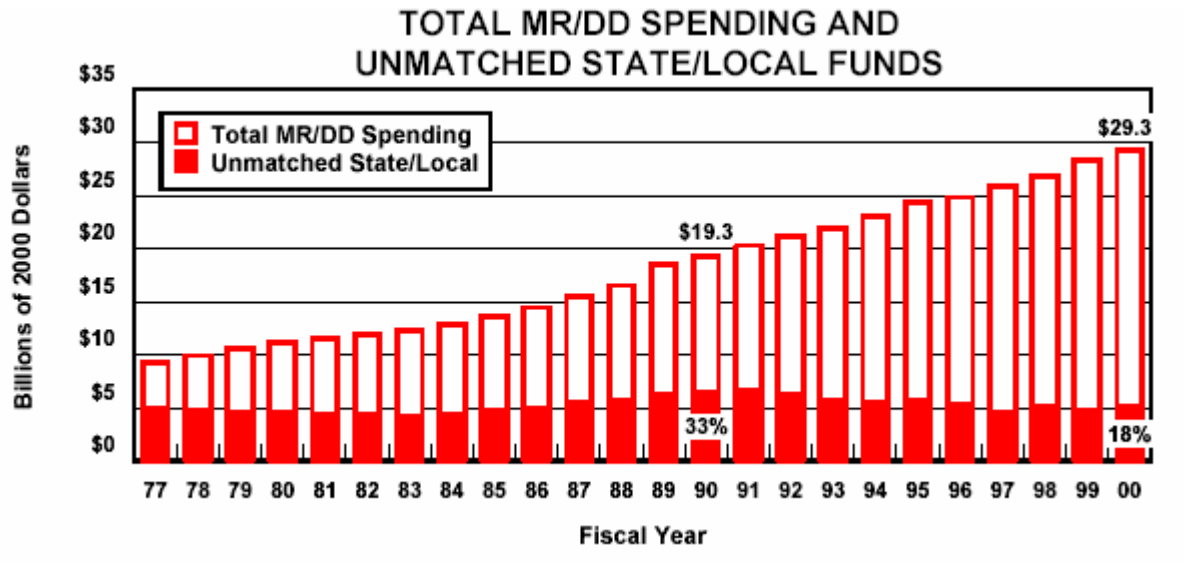


INDIANA

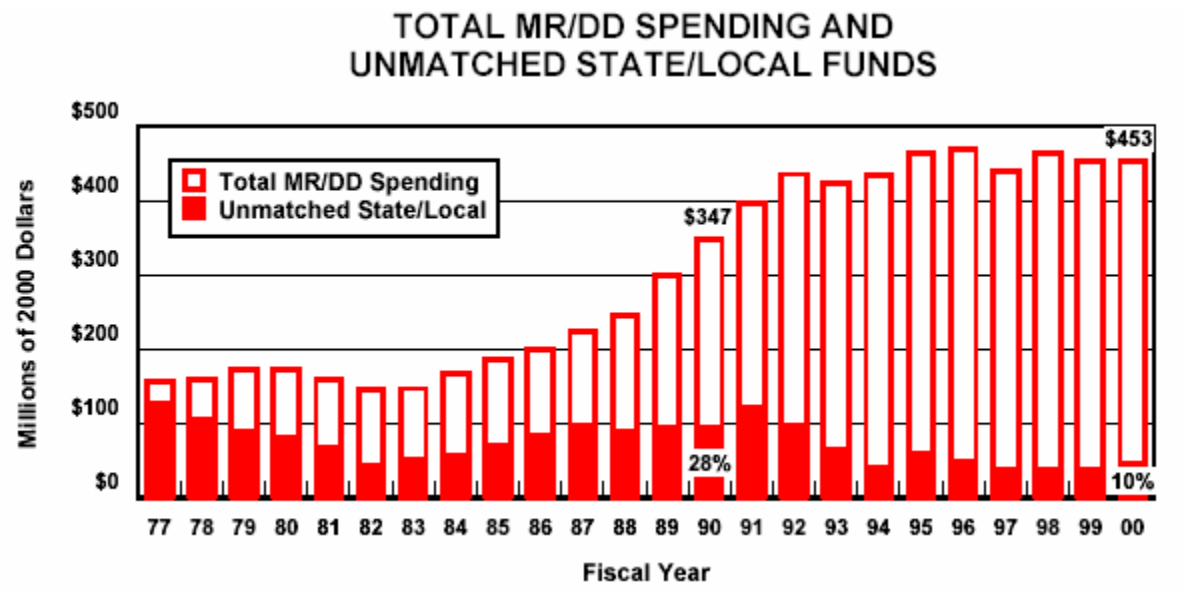


The Coleman Institute for Cognitive Disabilities measures ***fiscal effort*** as the amount spent for services as a percentage of personal income. For community-based services, Indiana's increase in fiscal effort since 1980 has been slower than the national average. Indiana has increased from $0.70 per $1,000 of personal income in 1980 to $2.24 in 2000 – an increase of 220%. Over the same period, however the national average grew from $0.75 to $2.75, an increase of 266%. In 2000 dollars, Indiana's fiscal effort for community based services ($2.24 per $1,000 of personal income) represents about 81% of the national average of $2.75.

UNITED STATES

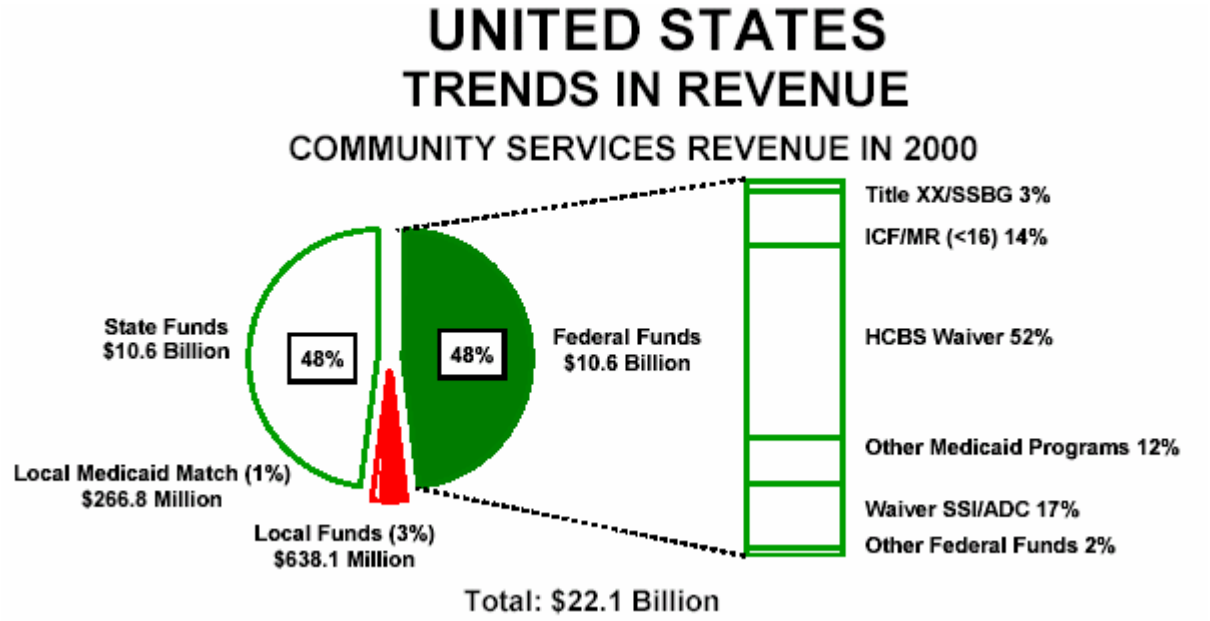


INDIANA

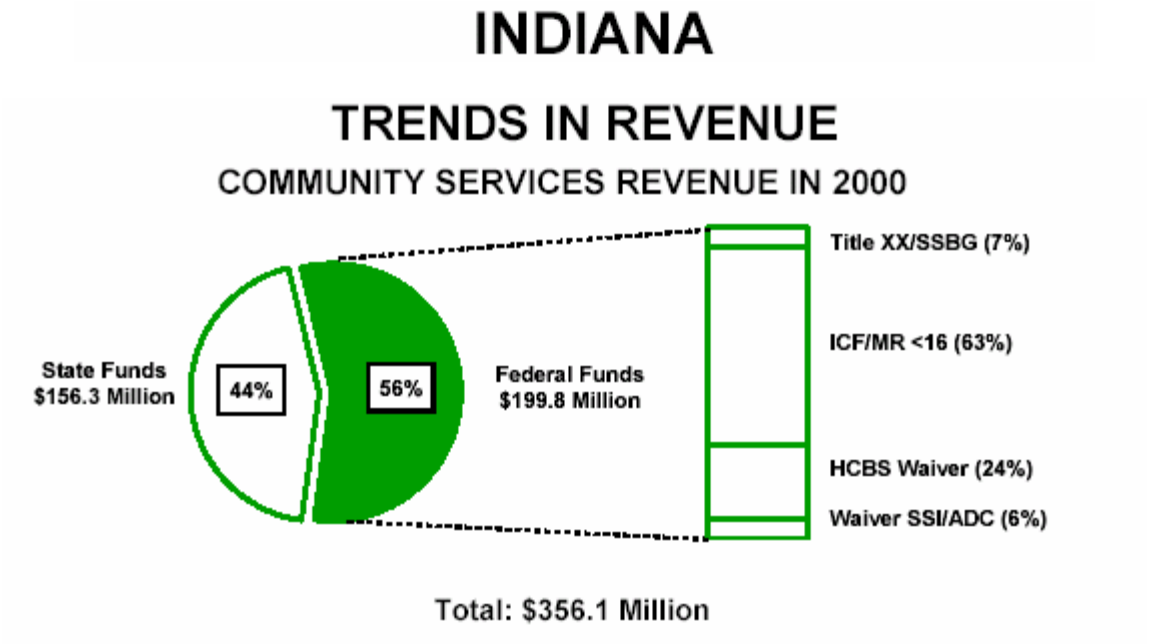


As shown in the chart above, Indiana began increasing spending for developmental disability (DD) services around 1982. In 2000 dollars, total state spending increased by 202% between 1982 and 2000. Over the same time period, the nation increased total spending for DD Services by about 144%.

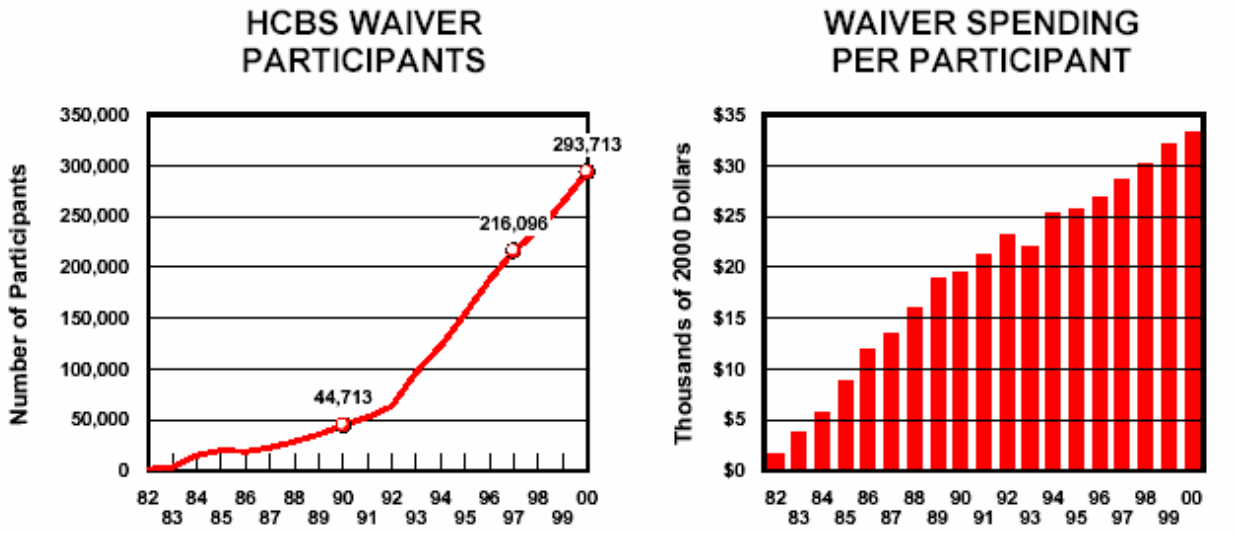
Another measure is the extent to which state and local funds are used to match, or leverage, federal funds. As of 2000, Indiana's level of unmatched spending was 10%. This compares to the national average of 18% for 2000. This leveraging effort is evident in the following charts as well.



In SFY 2000, state and local funds represented 52% of all funds expended for community services in the United States. In the same year, Indiana utilized 44% state dollars for community services. Although Indiana lagged the national average for leveraged funding by 8%, the State still spent 7% more than the required Medicaid match.

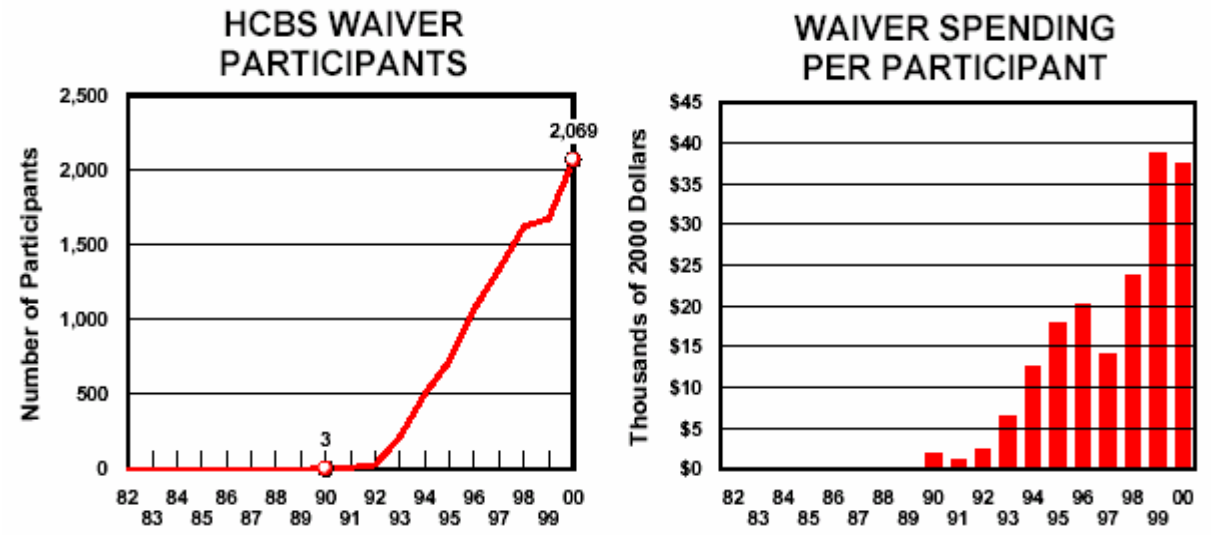


UNITED STATES

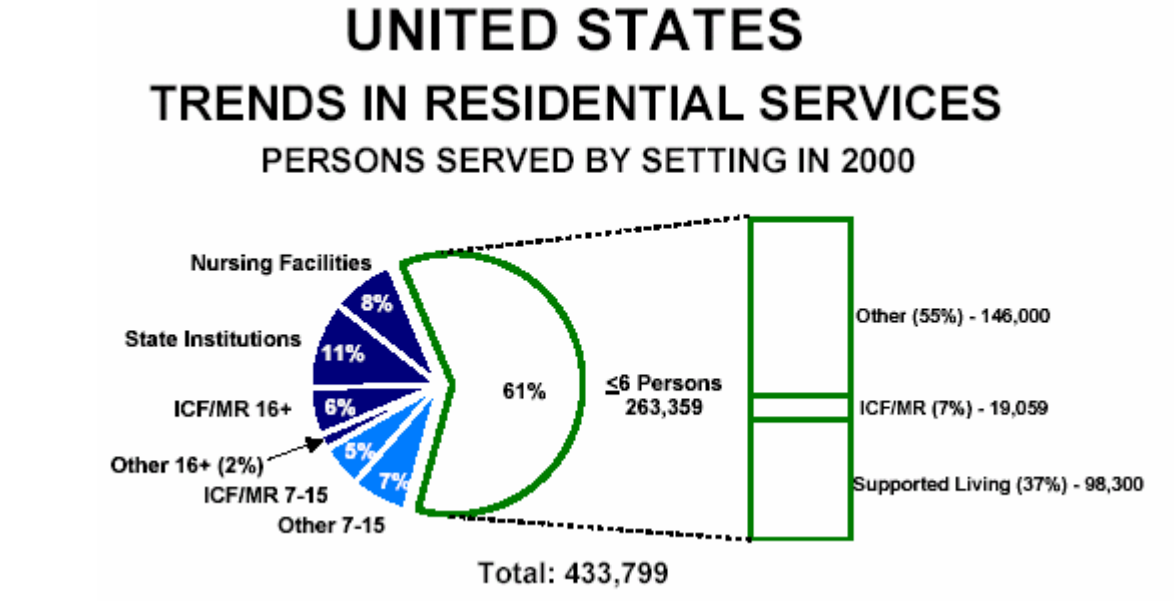


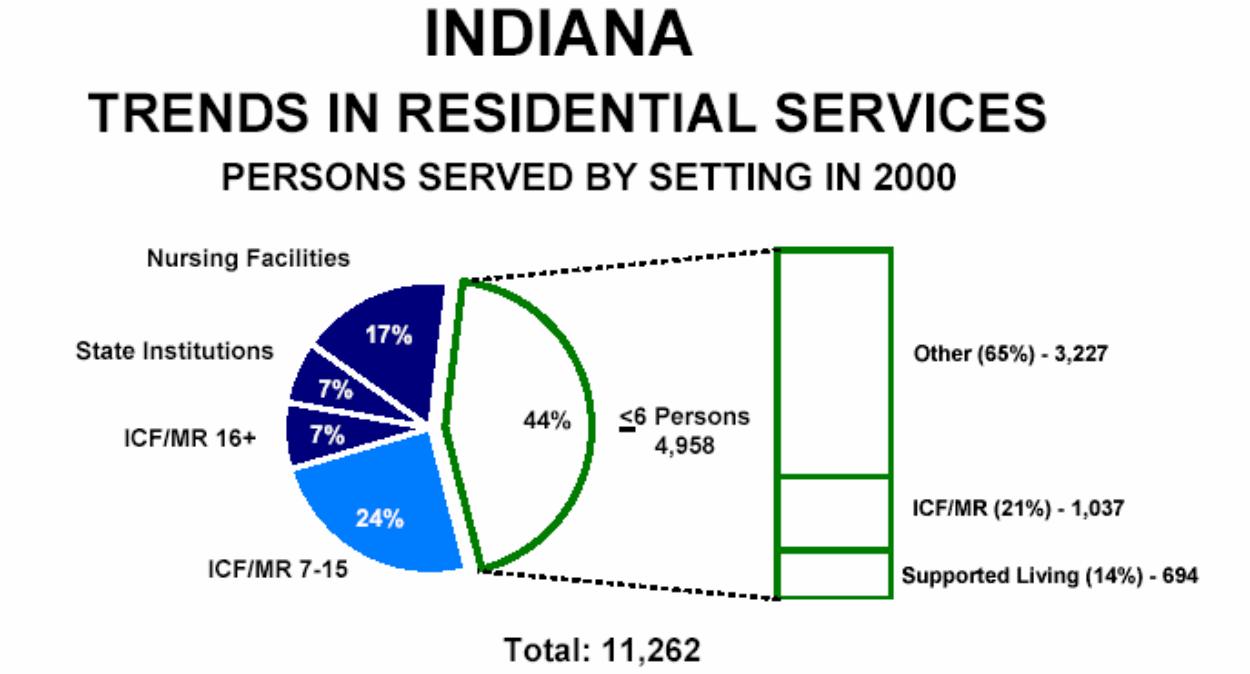
Although home and community-based waiver services grew from approximately $2000 per participant per year in 1982 to $33,000 by the year 2000, the number of participants increased from less than 100 nationwide to nearly 294,000 by 2000.

INDIANA



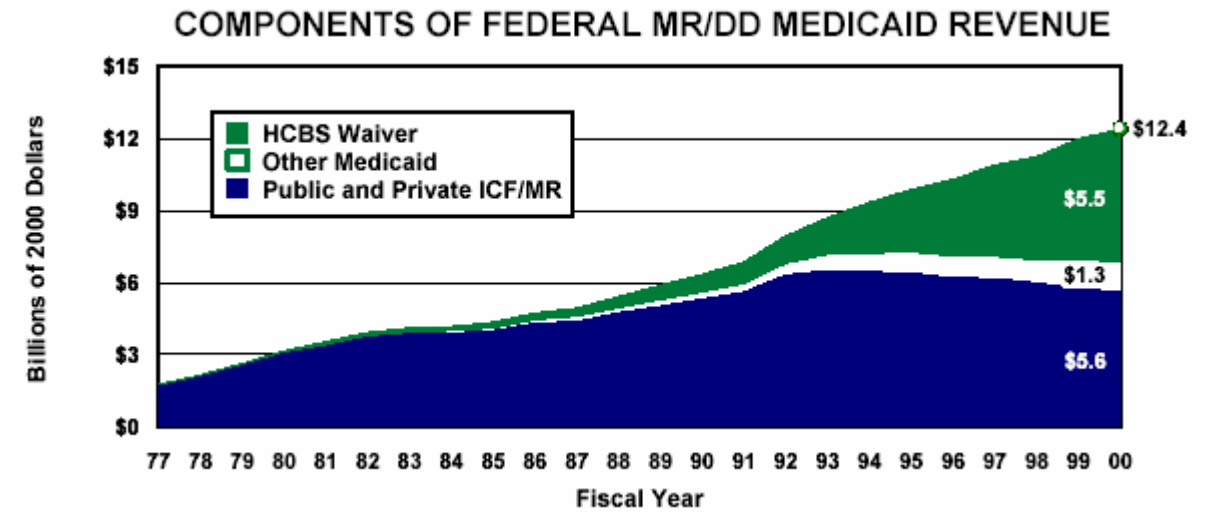
Indiana grew from spending approximately $1000 per waiver participant per year in 1990 to about $36,000 in 2000. Indiana's participant base also grew from a mere 3 waiver clients in 1990 to 2,069 by the year 2000. Although Indiana was slow to move toward providing waiver services and its growth inconsistent, overall its growth has kept pace with national trends.



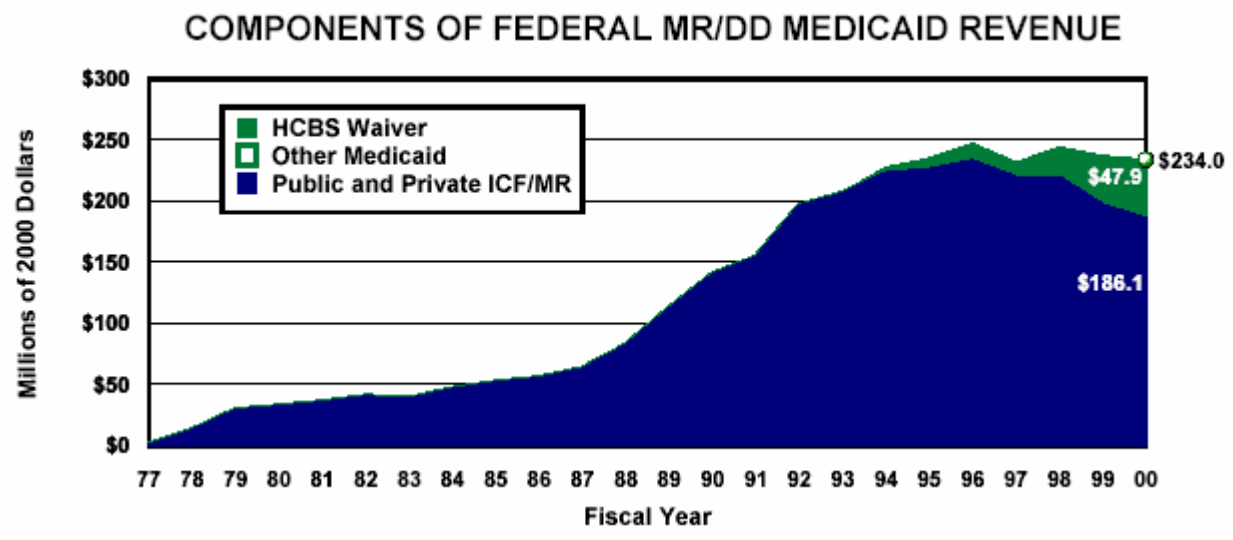


In terms of serving individuals in smaller settings, Indiana lags behind other states. The 2000 national average for individuals with MRDD served in settings of six people or less was 61%. In Indiana, however, the rate was only 44%. It is desirable to serve individuals in the least restrictive setting as possible since this approach maintains a more “home-like” environment. For additional information, please reference the charts on page 27 and 28.

UNITED STATES



INDIANA



Trends in Persons Served By Setting -- Developmental Disabilities

Unites States

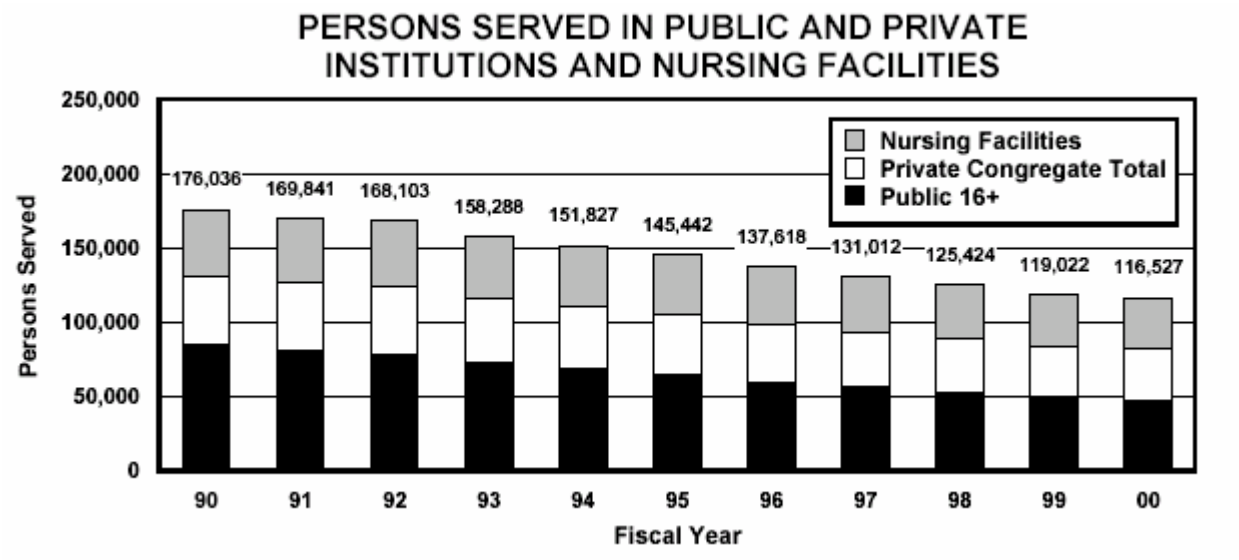
	1990	1995	1996	1997	1998	1999	2000	10-Year Change
TOTAL	**323,479**	**380,721**	**390,585**	**401,559**	**412,785**	**422,351**	**433,799**	**34.1%**
16+ PERSONS	**176,037**	**145,442**	**137,618**	**131,013**	**125,424**	**119,022**	**116,527**	**-33.8%**
Nursing Facilities	44,903	40,249	38,960	37,229	36,252	35,132	34,743	-22.6%
State Institutions	84,818	64,187	59,775	56,343	52,754	49,276	47,374	-44.1%
Private ICF/MR	32,926	30,752	28,777	27,744	27,271	26,218	26,107	-20.7%
Other Residential	13,389	10,255	10,106	9,696	9,147	8,396	8,303	-38.0%
7-15 PERSONS	**78,819**	**55,755**	**54,493**	**54,399**	**53,672**	**53,255**	**53,913**	**-31.6%**
Public ICF/MR	4,027	4,434	1,579	1,594	1,431	1,259	1,368	-66.0%
Private ICF/MR	21,008	23,197	23,443	22,949	22,813	21,818	21,927	4.4%
Other Residential	53,784	28,124	29,471	29,856	29,428	30,178	30,618	-43.1%
≤6 PERSONS	**68,623**	**179,524**	**198,475**	**216,148**	**233,689**	**250,074**	**263,359**	**283.8%**
Public ICF/MR	300	775	983	1,275	1,192	1,079	1,137	279.0%
Private ICF/MR	8,940	17,303	18,001	19,083	19,269	17,904	17,922	100.5%
Other Residential	59,383	161,446	179,491	195,790	213,228	231,091	244,300	311.4%

Indiana

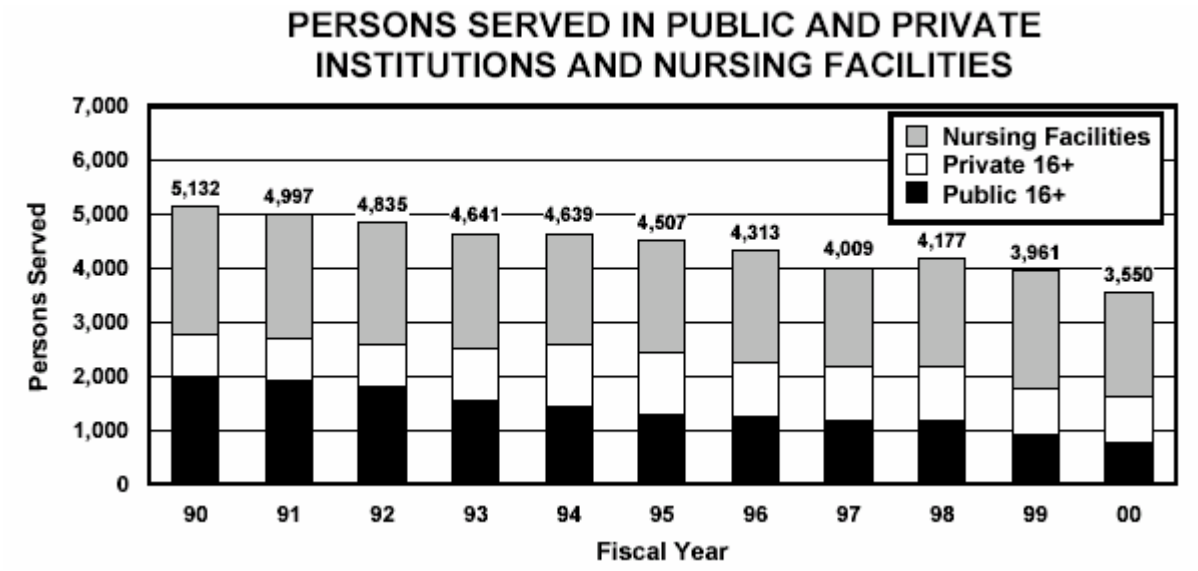
	1990	1995	1996	1997	1998	1999	2000	10-Year Change
TOTAL	**9,659**	**10,152**	**10,297**	**10,643**	**11,199**	**11,671**	**11,262**	**16.6%**
16+ PERSONS	**5,132**	**4,507**	**4,313**	**4,009**	**4,177**	**3,961**	**3,550**	**-30.8%**
Nursing Facilities	2,370	2,057	2,057	1,823	2,000	2,200	1,933	-18.4%
State Institutions	1,983	1,299	1,261	1,191	1,182	926	782	-60.6%
Private ICF/MR	779	1,151	995	995	995	835	835	7.2%
Other Residential	0	0	0	0	0	0	0	n/a
7-15 PERSONS	**1,327**	**2,767**	**2,767**	**2,763**	**2,763**	**2,754**	**2,754**	**107.5%**
Public ICF/MR	0	0	0	0	0	0	0	n/a
Private ICF/MR	1,327	2,767	2,767	2,763	2,763	2,754	2,754	107.5%
Other Residential	0	0	0	0	0	0	0	n/a
<6 PERSONS	**3,200**	**2,878**	**3,217**	**3,871**	**4,259**	**4,956**	**4,958**	**54.9%**
Public ICF/MR	0	0	0	0	0	0	0	n/a
Private ICF/MR	2,000	1,028	1,028	1,032	1,032	1,037	1,037	-48.2%
Other Residential	1,200	1,850	2,189	2,839	3,227	3,919	3,921	226.8%

Source: State of the States in Developmental Disabilities, 2001,
Coleman Institute for Cognitive Disabilities and Department of Psychiatry, University of Colorado

UNITED STATES



INDIANA



State	Fiscal Effort	Ranking
Rhode Island	$ 6.95	1
Maine	$ 6.53	2
New York	$ 5.99	3
North Dakota	$ 5.72	4
Vermont	$ 5.03	5
Minnesota	$ 5.03	6
D.C.	$ 4.61	7
Connecticut	$ 4.47	8
Wyoming	$ 4.25	9
West Virginia	$ 4.01	10
New Mexico	$ 3.98	11
Massachusetts	$ 3.81	12
Idaho	$ 3.81	13
South Dakota	$ 3.76	14
Kansas	$ 3.57	15
Oregon	$ 3.44	16
Alaska	$ 3.42	17
Ohio	$ 3.35	18
Oklahoma	$ 3.33	19
Montana	$ 3.32	20
New Hampshire	$ 3.30	21
Michigan	$ 3.29	22
Pennsylvania	$ 3.25	23
Wisconsin	$ 3.22	24
South Carolina	$ 3.16	25
Iowa	$ 3.07	26
North Carolina	$ 2.94	27
Louisiana	$ 2.82	28
Arizona	$ 2.76	29
Nebraska	$ 2.67	30
Missouri	$ 2.39	31
Arkansas	$ 2.31	32
California	$ 2.27	33
Indiana	**$ 2.24**	**34**
Utah	$ 2.23	35
Colorado	$ 2.22	36
Washington	$ 2.22	37
Maryland	$ 2.11	38
Tennessee	$ 1.99	39
Delaware	$ 1.99	40
New Jersey	$ 1.86	41
Illinois	$ 1.74	42
Texas	$ 1.73	43
Hawaii	$ 1.34	44
Virginia	$ 1.31	45
Alabama	$ 1.28	46
Mississippi	$ 1.24	47
Florida	$ 1.13	48
Kentucky	$ 1.07	49
Georgia	$ 1.06	50
Nevada	$ 0.72	51

Community Fiscal Effort and State Ranking, 2000

Note: Fiscal effort represents the proportion of total statewide personal income which is devoted to the financing of developmental disabilities community and Individual & Family Support services. Fiscal effort (Column 2) is expressed in $s per $1,000 of

Source: Braddock, Hemp, Rizzolo, Parish & Pomeranz. (2002). The State of the States in Developmental Disabilities: 2002 Study Summary. Boulder, CO: The Coleman Institute for Cognitive Disabilities and Department of Psychiatry.

HCBS Waiver Federal/State Spending as a % of Total Mental Retardation/Developmental Disability Spending, 2000

	Rank (by waiver spending as % of total MR/DD spending)	State	Fed/State Waiver Funding	Number of Participants	Waiver Cost Per Participant	Waiver % of Total MR/DD Spending
	1	Vermont	$ 63,714,498	1,719	$37,065	80%
	2	New Hampshire	$ 99,742,724	2,638	$37,810	76%
	3	New Mexico	$ 110,293,519	2,160	$51,062	70%
	4	Rhode Island	$ 145,595,178	2,471	$58,922	68%
	5	Colorado	$ 203,772,399	5,799	$35,139	64%
	6	Arizona	$ 227,104,692	10,816	$20,998	62%
	7	Wyoming	$ 44,191,916	1,226	$36,046	60%
	8	Maine	$ 127,940,702	1,840	$69,533	59%
	9	South Dakota	$ 50,126,302	1,988	$25,214	57%
	10	Kansas	$ 169,359,274	5,500	$30,793	54%
	11	Oregon	$ 188,974,566	5,858	$32,259	53%
	12	West Virginia	$ 85,143,110	1,910	$44,578	53%
	13	Minnesota	$ 434,629,020	7,689	$56,526	53%
	14	Hawaii	$ 22,952,448	1,089	$21,077	50%
	15	Alaska	$ 31,112,865	681	$45,687	50%
	16	Nebraska	$ 84,264,420	2,320	$36,321	49%
	17	Alabama	$ 96,099,599	4,337	$22,158	48%
	18	Michigan	$ 468,386,750	8,300	$56,432	47%
	19	Maryland	$ 190,040,934	4,982	$38,146	44%
	20	Utah	$ 73,724,680	3,147	$23,427	44%
	21	Connecticut	$ 349,256,916	4,783	$73,020	44%
	22	Massachusetts	$ 465,896,852	11,360	$41,012	43%
	23	Oklahoma	$ 154,586,108	3,276	$47,187	43%
	24	Wisconsin	$ 292,877,847	8,865	$33,038	42%
	25	Pennsylvania	$ 660,766,466	15,943	$41,446	42%
	26	Montana	$ 33,564,652	1,276	$26,305	41%
	27	Tennessee	$ 188,112,207	4,318	$43,565	40%
	28	New York	$ 1,697,262,148	38,696	$43,861	40%
	29	Delaware	$ 31,502,716	489	$64,423	36%
	30	North Dakota	$ 39,537,856	1,923	$20,561	36%
	31	Missouri	$ 184,892,127	7,775	$23,780	35%
	32	Washington	$ 189,515,894	10,530	$17,998	35%
	33	Florida	$ 239,004,632	20,442	$11,692	33%
	34	Kentucky	$ 60,418,737	1,200	$50,349	32%
	35	Virginia	$ 144,459,211	4,698	$30,749	31%
	36	New Jersey	$ 296,254,000	6,894	$42,973	31%
	37	South Carolina	$ 113,050,202	4,489	$25,184	28%
	38	Georgia	$ 100,768,711	3,612	$27,898	26%
	39	Nevada	$ 13,150,358	950	$13,842	22%
	40	Iowa	$ 83,874,760	4,591	$18,269	21%
	41	North Carolina	$ 181,783,394	5,735	$31,697	21%
	42	Louisiana	$ 95,425,105	3,450	$27,659	19%
	43	California	$ 550,325,374	28,233	$19,492	18%
*	**44**	**Indiana**	**$ 77,731,833**	**2,069**	**$37,570**	**17%**
	45	Texas	$ 236,768,125	5,140	$46,064	16%
	46	Arkansas	$ 32,361,114	2,012	$16,084	13%
	47	Illinois	$ 148,731,384	7,400	$20,099	13%
	48	Ohio	$ 182,120,027	5,593	$32,562	12%
	49	Idaho	$ 14,883,847	653	$22,793	11%
	50	Mississippi	$ 4,421,843	848	$5,214	2%
		United States	**$ 9,780,474,043**	**293,713**	**$33,299**	**33%**

6. **Education**

Education is an important component of achieving and maintaining independence. In Indiana, 82% of the population age 25 or older has achieved at least a high school education. This can be compared to the national average of 80%.[xxii]

According to the National Organization on Disabilities, 22% of Americans with disabilities fail to complete high school as compared to only 9 % of students without a disability. It is also less likely for persons with disabilities to have graduated from college than their non-disabled counterparts (12% versus 23%).

The degree of disability has a significant impact on educational achievement. Those with slight disabilities are more likely to complete high school (83%) and college (16%) than people with very severe disabilities (67% high school graduate; 9% college graduate), though they are still less likely to be high school and college graduates than people without disabilities (90% high school graduate; 23% college graduate).

Over the past 14 years, the educational gap has narrowed considerably between people with and without disabilities by 24 % in 1986 to 13% today. In 1986, almost 4 out of 10 people with disabilities (39%) failed to complete high school. Today, approximately 2 out of 10 people with disabilities (22%) have not completed high school.

The opposite is true when it comes to graduating from college. Since 1998, there appears to have been a decline from 30% to 26% among people with disabilities who have completed some college, and an even sharper decline from 19% to 12% for people with disabilities who graduated from college**.** [xvii]

SECTION III: DOORS TO SERVICES

This section of the Data Book is designed to illustrate how individuals access services in Indiana. The intent is to highlight the process of accessing services for the elderly, mentally ill, disabled, and/or children dependent on public services to access care.

1. *Division of Family Resources/Department of Child Services County Offices*

The Local Office of the Division of Family Resources (DFR)/Department of Child Services (DCS) is where applications are taken and submitted for assistance with the following services:

- TANF
- Food Stamps
- Medicaid
- SSI eligibility determination
- Hoosier Healthwise (Medicaid programs for children)
- IMPACT
- Child Support Services
- Family Protection and Preservation

There is an Office of Family Resources/Child Services in all 92 Indiana Counties that administers Public Assistance Programs and Family Protection and Preservation Programs. A local office is available in the county seat and in various neighborhoods/townships when applying for benefits in larger communities. The application process originates in the local office. Once an application is filed with the local office, a caseworker is assigned and an appointment is set. The caseworker determines service need and financial eligibility based upon the information gathered in the application process. This process can be lengthy and may require more than one visit to the local office. The process can be particularly burdensome to one with limited mobility or lack of transportation. Locations of Family and Children local offices can be accessed at http://www.in.gov/fssa/children/dfc/directory/index.html or by phone at 317-232-4704.

2. *Area Agencies On Aging*

Applications for the following services are made at one of Indiana's Area Agencies on Aging:

- Developmental Disability Waiver;
- Support services Waiver;
- Title V: Senior Employment;
- Pre-Admission Screening;
- Congregate Meals;
- CHOICE

Indiana's Area Agencies on Aging provide case management and information and referral to various services for persons who are aging or developmentally disabled. They can also assist the elderly client interested in employment or assistance with activities, parents of a child with a disability, or a community member suspecting abuse and neglect of a dependent adult.

They also serve as the single point of entry for the IN-Home Services Program. There are 16 AAA agencies throughout the state. One can determine the nearest location by reviewing the list at http://www.state.in.us/fssa/elderly/aaa/index.html, or by telephone at 1-800-986-3505.

3. ***Community Mental Health Centers (CMHCs)***

Applications for the following services are made at one of Indiana's Comprehensive Mental Health Centers:

- Medicaid Rehabilitation Option (MRO)
- Inpatient Services
- Residential Services
- Partial Hospitalization Services
- Outpatient Services
- Operate 72-hour Crisis Service
- Consultation-Education Services
- Community Support Program

Community Mental Health Centers (CMHCs) are providers of mental health services that operate on behalf of the Family and Social Services Administration Division of Mental Health and Addictions. There are thirty comprehensive mental health centers located throughout the state. http://www.in.gov/fssa/servicemental/faq/2cchild&adoles.html is the web address or one may call 1-800-901-1133 to find the nearest location.

4. ***Vocational Rehabilitation Offices***

Applications for these services can be made at one of Indiana's Vocational Rehabilitation Offices:

- Vocational Rehabilitation Services (VRS)
- Supported Employment (SE)
- Independent Living (IL) Services
- Assistive Technology through Awareness in Indiana (ATTAIN)

The Bureau of Vocational Rehabilitation provides quality, individualized services to enhance and support people with disabilities to prepare for, obtain or retain employment. Through active participation in their rehabilitation, people with disabilities can achieve a greater level of independence in both their work place and living environments.

Persons eligible for vocational rehabilitation services may include: persons who have a physical or mental impairment; persons whose impairment constitutes or results in a substantial impediment to employment; persons who can benefit in terms of an employment outcome from the provision of vocational rehabilitation services; and persons who require services to help prepare for gainful employment.

There are twenty-five area vocational rehabilitation offices divided into five regions. A complete list of offices is available at http://www.in.gov/fssa/servicedisabl/vr/offices.html or by calling 317-232-7000.

5. ***State-Wide Network of Rehabilitation Facilities Working in Conjunction with The Bureau of Developmental Disabilities***

Application for the following programs and related services are made at one of the local sites detailed below:

- Developmental Disability Day Services
- Autism Waiver
- Family Subsidy Program
- Case Management Services
- Diagnosis and Evaluations for Determine Status of Developmental Disability
- Traumatic Brain Injury Waiver
- Aged and Disabled Waiver
- Developmentally Delayed Waiver
- First Steps

The Bureau of Developmental Disabilities develops and administers a variety of services for people who have developmental disabilities. Services available for persons with disabilities are community-based residential alternatives to placement in state institutions and heath facilities. Programs support independent living in the least restrictive environment possible and are based on a person-centered planning process. Access is available through nine district agencies throughout the state. A complete list of offices is available at: http://www.in.gov/fssa/servicedisabl/field/index.html or by calling 1-800-545-7763.

SECTION IV: PROGRAMS

1. *Housing*

A. Indiana's Housing Choice Voucher Program (Section 8)

Section 8 provides very low-income households with rental assistance. There are currently 3,700 households receiving housing assistance through this program. Two-thirds of those households have an elderly or disabled family member. However, demand is especially high for this program and there are over 7,000 households on the pre-application list waiting for assistance.[xxiii] In federal fiscal year 2001, Indiana received $17.4 million dollars in funding for the Section 8 program from the US Department of Housing and Urban Development (HUD).

B. Section 8 Family Self-Sufficiency Program (FSS)

Indiana's Housing Choice Voucher Program and Family Self-Sufficiency (FSS) Program, administered by DFR's Housing and Community Services Section provides rental voucher assistance in conjunction with public and private-sector services and resources that can help residents of assisted housing achieve economic independence. Use of housing as a stabilizing force permits the families to invest their energy into other sustaining efforts including employment, education, and job training that are necessary to achieve self-sufficiency.

To be eligible, families must be current voucher holders. Participants in the FSS Program are provided with an opportunity to save for the future through the FSS Escrow Account. Increases in the family's contribution for rent, due to increases in earned income, are credited to an interest bearing escrow account. After the family successfully completes the program, the escrow balance can be withdrawn by the family to be used in any manner. Most FSS Program participants have used the escrow monies to continue working, buy an automobile, or make a down payment on a home.

To date there have been 35 graduates of the program. The average escrow check amounts has ranged between $3,500 and $4,500. In the last 12 months, the FSS Program has awarded a total of $59,134.96 to participants who have successfully completed the program. Participating Community Action Agencies, under contract with the Division of Family Resources manage the program throughout the entire year.

C. The Family Unification Program (FUP)

The program provides housing assistance vouchers to families with children at-risk of an out-of-home placement due to lack of adequate housing. HUD provides Indiana with funding for the program. There are 200 housing units available statewide under this program. Currently, all units are full.

D. The Mainstream Program

A joint DDARS and DFR initiative, the project is designed to provide rental assistance vouchers to enable any person with a disability, regardless of age to rent affordable private housing. The Program targets very low-income, disables families who are on the Housing Choice Voucher waiting list of applicants. DDARS refers clients to the program, provides caseworker assistance to the eligible individuals in finding suitable housing, and provides on-going case management and

support. Mainstream Program recipients may live in mobile homes, apartments, doubles, single homes, etc. However, the program does not provide assistance to live in congregate settings such as nursing homes or schools.[xxiv]

2. ***Transportation***

In CY2001, INDOT awarded more than $1.7 million in capital grants to over 60 counties and 83 non-profit social service agencies for vehicles and related equipment repair to ensure services for the elderly and disabled. It is estimated that these grants result in over 500,000 one-way trips (statewide) each year[xxv].

Although Medicaid-funded transportation services are provided only to persons receiving Medicaid for use when receiving a Medicaid-approved medical service, Indiana spent $32,171,000 on Medicaid transportation services in SFY 2002. Even though these expenditures appear significant compared to other Indiana transportation programs, Medicaid transportation expenditures represent less than 1% of total Medicaid expenditures. xxxi

3. ***Vocational Services***

A. Vocational Rehabilitation Services (VRS)

Vocational Rehabilitation Services (VRS) is a State-Federal partnership program first established in 1920. The purpose of VRS is to assist eligible individuals with disabilities in achieving employment and independence. A major focus of the VRS program is to enable individual customers to have primary input into their own rehabilitation programs.

Eligibility for VRS is based on federal requirements. A person is eligible if he or she has a physical or mental impairment which is a substantial impediment to employment *and* he or she needs vocational rehabilitation services in order to enter, prepare for, engage in, or retain employment.

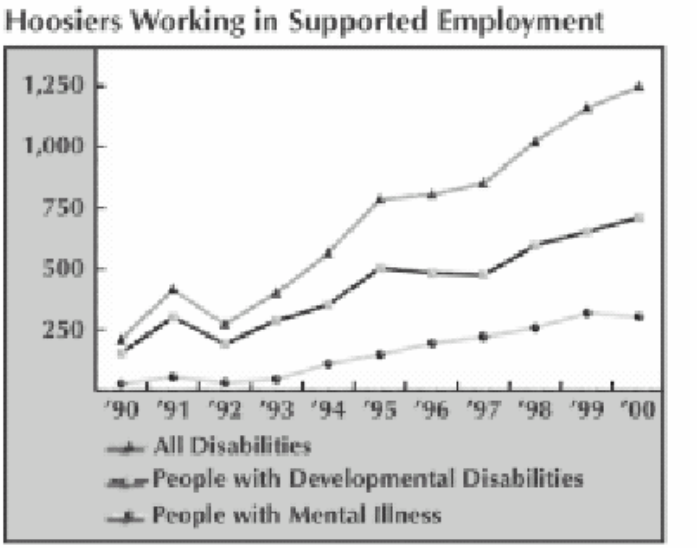
In SFY 1999, 4351 Indiana residents were placed in employment through FSSA's Vocational Rehabilitation program, up from 3,641 in FY 1995.[xxvi]

B. Supported Employment

Individuals with the most severe disabilities are placed in competitive jobs with qualified job coaches/trainers to provide individualized, ongoing support services needed for each individual to retain employment. The employer is contacted monthly and the employee is visited twice monthly to address any issues that may threaten the individual's ability to remain on the job.

DMHA provides the Office of Vocational Rehabilitation with funds to enable them to build supported employment programs. Currently, more than 26 community mental health centers offer supported employment programs throughout the state, a dramatic increase from the single CMHC offering such services in 1990. There are more than 700 people with Mental Illness in supported employment in Indiana at a cost of $1.1 million.

Since 1999, an average of 772 individuals has been enrolled in a supported employment programs each year.[xxvii] Researchers at Ball State University have been collecting data from supported employment programs throughout Indiana. Research shows that about 55 percent of those who enter a supported employment program will secure employment.[xxviii]

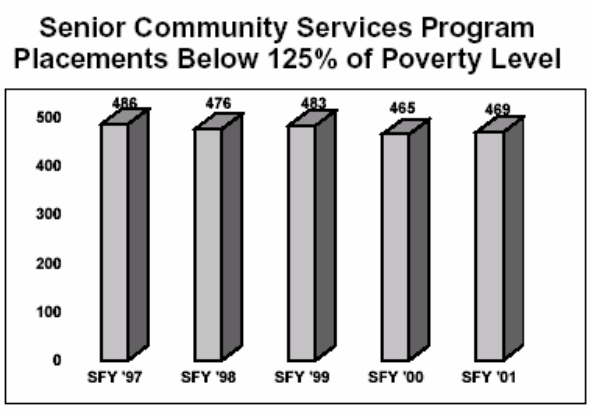


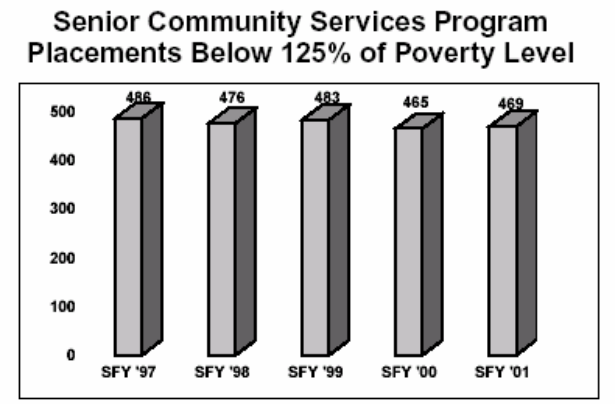
C. Senior Employment Program

The Older Americans Act of 1965, as amended, authorized the establishment of the Title V Community Service Employment Program. This program is commonly referred to as the Title V Senior Employment Program. The purpose of the Title V Senior Employment Program is to provide meaningful part-time work opportunities in community service for those 125% or below the federal poverty level and are 55 years of age or older with poor employment prospects (as defined under 42 U.S.C. 1397). The desired outcome of this program is to provide meaningful employment and training to low-income persons aged 55 years or older and who have poor employment prospects. Initially, the U.S. Department of Labor subsidizes wages.

In SFY 2001, the Title V Senior Employment Program served 469 Hoosiers. The majority of individuals served were women between 60 and 74 years of age. The U.S. Department of Labor has established a goal of placing 20% of the Title V clients in unsubsidized employment. Indiana exceeded this goal by placing 21.2% of the clients in unsubsidized employment.

The Title V program is funded primarily through the U.S. Department of Labor. Federal funds equaling $2,074,714 were expended in SFY 2001 and matched with $340,625 in state and local funding. In addition, administrative expenses were $68,979, matched with 90% federal dollars.





D. Impact

The Indiana Manpower and Comprehensive Training (IMPACT) Program provides services designed to help Food Stamp and TANF beneficiaries achieve economic self-sufficiency through education, training, job search and job placement activities.

The IMPACT program assists participants in meeting these goals through an approach that emphasizes job placement and job retention complemented by education and training activities. The participant's movement toward the goal is assisted by IMPACT case management, which coordinates an array of services, including education, training, job search, job placement, and social services offered by the Indiana Family and Social Services Administration through the Division of Family and Children and local providers.

IMPACT is Indiana's Welfare-to-Work program – a critical component of Indiana's welfare reform initiatives – which places an increasing emphasis on "work first." "Work first" means that individuals are expected to accept a job which can be secured with their existing education and skills.

Waivers from the U.S. Department of Health and Human Services and the U.S. Department of Agriculture provide "work pays" incentives to assist clients. Financial barriers to moving toward self-sufficiency have been reduced by Indiana's welfare reform initiatives. As an important link in the welfare reform program, IMPACT places and increasing priority on participants, retention, and wage gain with a "work first" focus along with a holistic approach to the whole family.

IMPACT is much more than a job training program, however, in that it seeks to address a broad range of barriers that clients may have in locating and maintaining employment.

From the time an individual applies for assistance, employment services are available and individuals are asked to begin their job search. For those not able to find a job right away, additional activities are provided. An assessment of the client's strengths and needs is completed and a case manager works with the client to develop an individualized plan for employment. The plan outlines the steps which will be taken for the client to become self-sufficient.

In addition to job search, the activities could include job readiness activities or an unpaid work experience at an agency. In addition to a work activity, appropriate vocational training or basic education classes might be included on the employment plan. The plan also includes supportive services such as transportation and child care.

To assist in this endeavor, the program has increased the provider contracts for job search, job readiness, job development, job placement and retention as well as providing services to the whole family and outreach to the faith-based community as service providers. Indiana was selected by the National Governor's Association as one of seven states selected to pilot workforce innovations for the incumbent worker in partnership with the Indiana Department of Workforce Development and the Indiana Economic Development Council.

State Fiscal Year	Job Placements
1993	3,982
1994	4,665
1995	9,483
1996	19,906
1997	27,349
1998	33,500
1999	25,382
2000	23,216

E. Temporary Assistance to Needy Families (TANF)

TANF is a program that provides cash assistance and social services to assist the family, helping them achieve economic self-sufficiency.

Although the TANF Block Grant provides the funding for varied social services and benefits to low-income families, the primary program funded by the block is the cash assistance program.

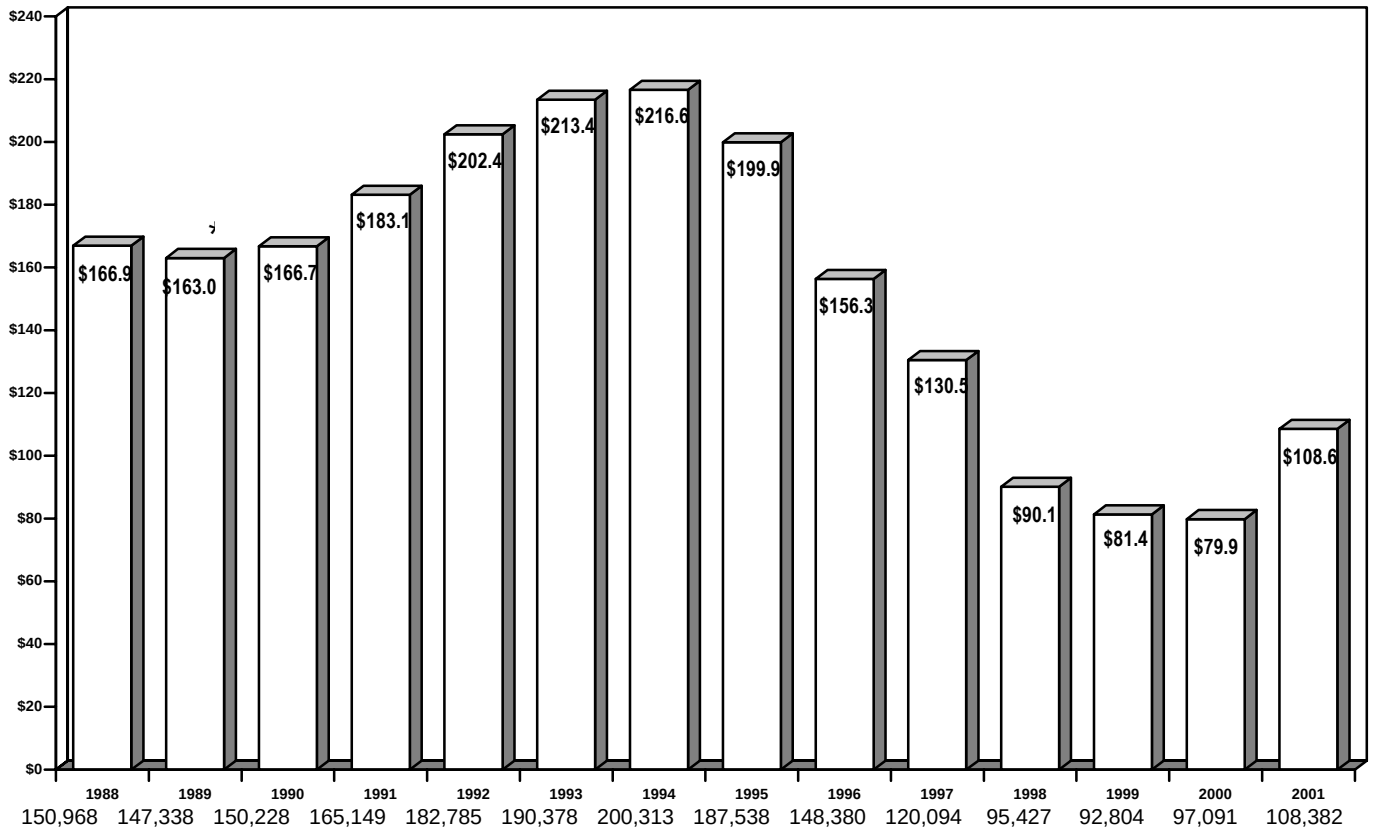
Indiana's cash assistance program is part of the State's Welfare Reform Demonstration Project. This demonstration includes the employment and training services provided to those families receiving cash assistance. Those assigned to the demonstration treatment group are required to cooperate with policies which address personal responsibility, child immunization and school attendance, maintenance of a safe and secure home, prohibition of substance abuse, and a 24-month time limit on cash assistance for those who are required to participate in employment activities. Additional provisions include more stringent penalties and employment incentives than the traditional AFDC Program. Those assigned to the control group are subject to the conditions of the former AFDC Program.

TANF beneficiaries include families with children under the age of 18, that are deprived of financial support from a parent by reason of death, absence from the home, unemployment, or physical or mental incapacity. Assets are both liquid and non-liquid. Therefore, an applicant may not have assets valued in excess of $1,000 at the time of application. Subsequent to application, the Treatment Group has an asset limit of $1500. In addition, individual members must provide their Social Security numbers and meet state residency and citizenship/alien requirements. Individual family members who do not meet exemption criteria must register for Indiana's Manpower Placement and Comprehensive Training (IMPACT) program, as well as cooperate with the Child Support Enforcement Program.

Temporary Assistance For Needy Families
Total TANF Regular Expenditures For
State Fiscal Years 1988 - 2001

Millions Of Dollars

Monthly Average Recipients (excluding zero grants)

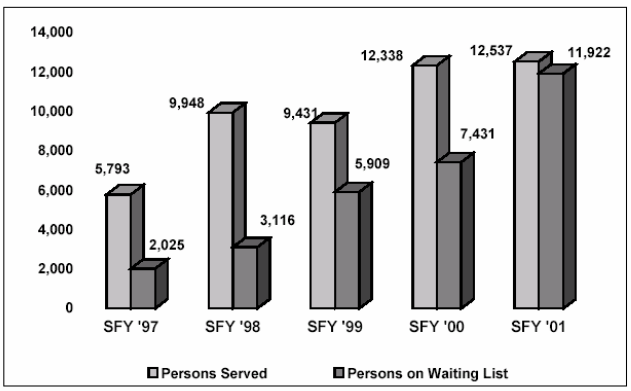


4. ***Community and Personal Assistance Support Services***

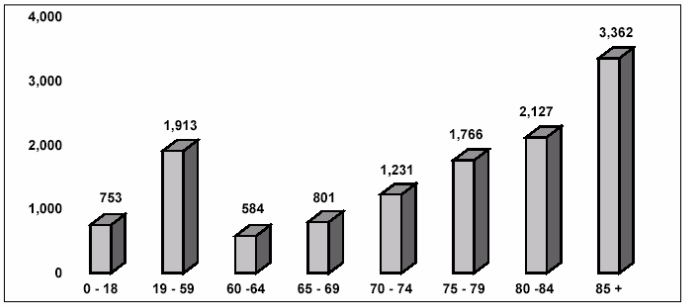
A. The Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Program

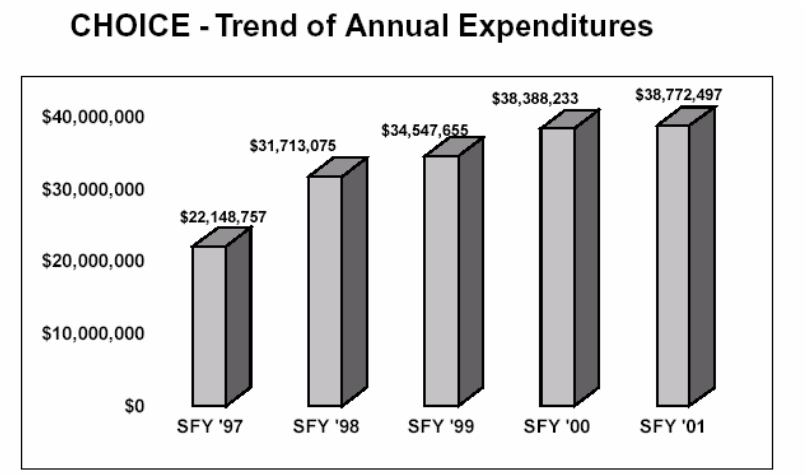
The CHOICE Program was established during the 1987 legislative session through House Enrolled Act (HEA) 1094 and began as a pilot program in Knox, Daviess, and Tippecanoe counties in 1988. The program went through several expansions that resulted in services being extended to all of Indiana's 92 counties by 1992. The program is available to person age 60 years of age and older, rform two or more activities of daily living as n Care Services Eligibility Screen. In SFY2001, a cost of $38.8M. This translates to roughly .000 persons, more than 7,000 remain on the

Persons Served by Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) vs. Persons on Waiting List



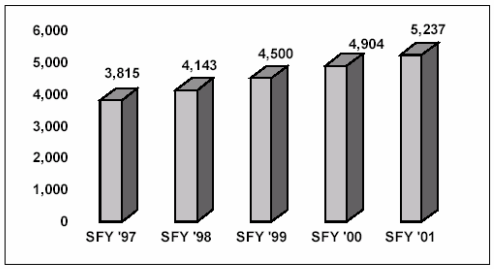
Ages of Persons Served by CHOICE in SFY 01

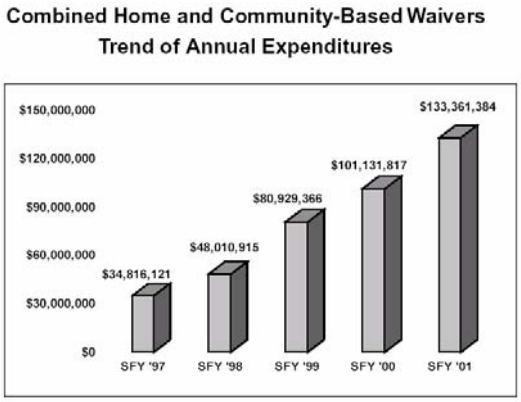




B. Waivers

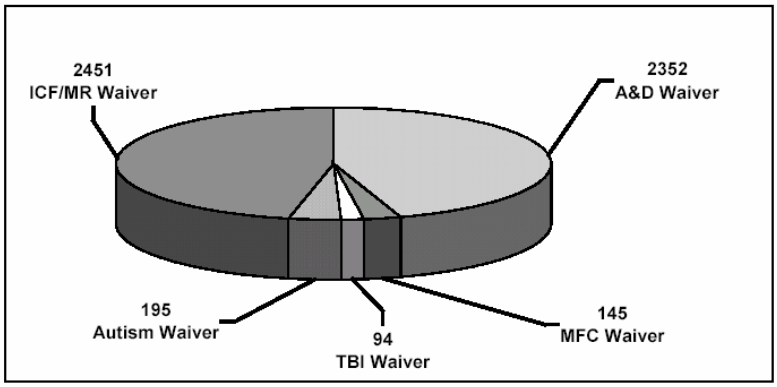
Medicaid waivers allow Indiana to provide a variety of in-home and community-based services to individuals who would otherwise require the level of care provided in an institutional setting. These



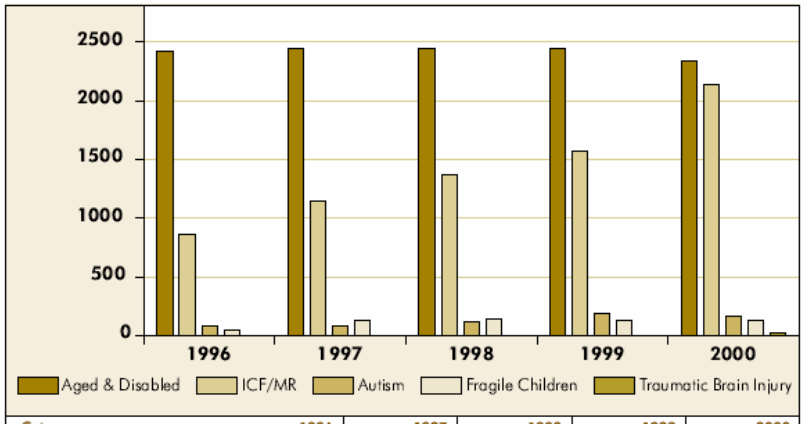


five Medicaid Waivers served a combined total of 5,237 individuals in SFY 2001 at a cost of $133.3 million.

By 2001, there were five Medicaid Waivers administered by DDARS allocated as such:



Waiver Recipients by Category [Figure 9]



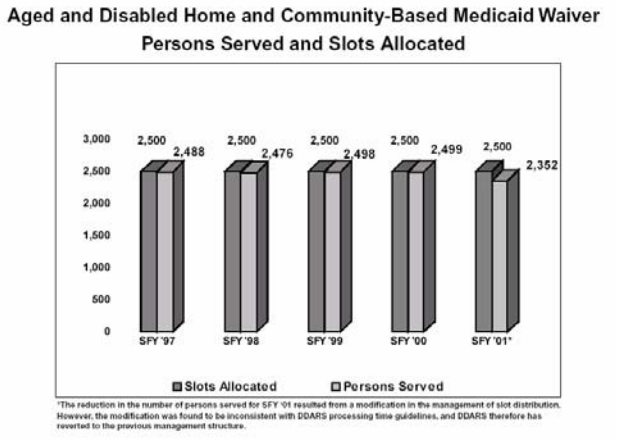
Category	1996	1997	1998	1999	2000
Aged & Disabled	2,422	2,448	2,445	2,447	2,343
ICF/MR	859	1,150	1,375	1,572	2,137
Autism	82	88	120	184	169
Fragile Children	50	129	138	134	134
Traumatic Brain Injury	-	-	-	-	28
Total	3,413	3,815	4,078	4,337	4,811

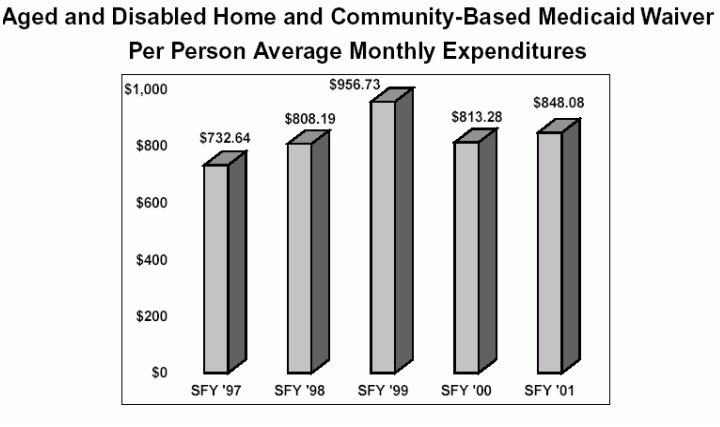
Waiver waiting lists at end of year SFY 2002
(www.in.gov/fssa/qtrreports.html)

Waiver Program	Waiting List as of 6/1/02
Aged and Disabled Waiver	2339
Autism Waiver	316
Developmental Disabilities Waiver	3473
Medically Fragile Children Waiver	222
Traumatic Brain Injury Waiver	80

i. Aged and Disabled Waiver

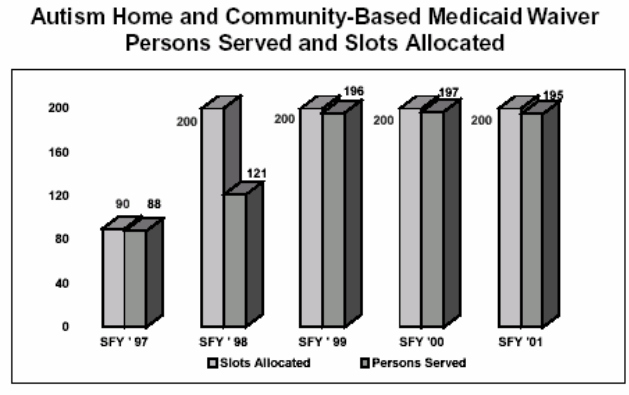
This waiver serves individuals who meet the Medicaid guidelines and either 65 years of age or have disabilities. Individuals served by this waiver must meet level of care standards of a skilled or intermediate nursing facility.

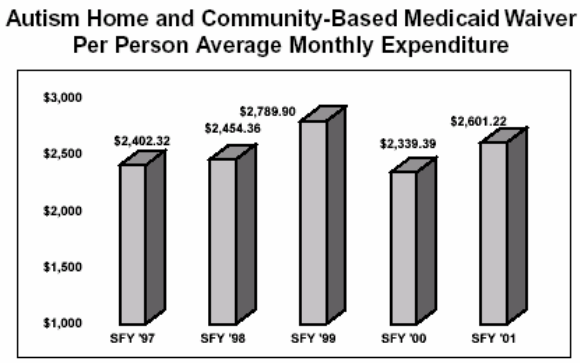




ii. Autism Waiver

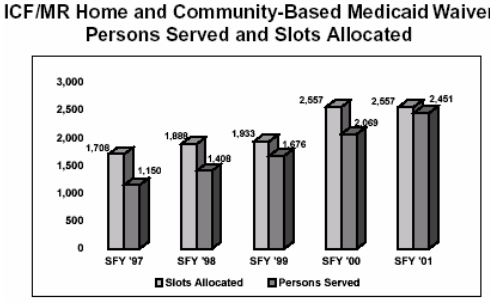
The autism waiver serves individuals with a diagnosis of autism who meet an intermediate care facility for mental retardation level of care.

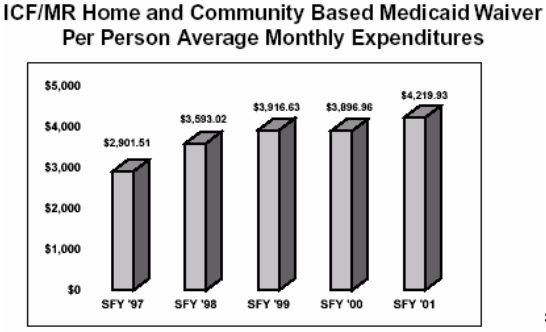




iii. Intermediate Care Facility for Mental Retardation (ICF/MR) Waiver

Serves individuals with developmental disabilities/mental retardation and other related conditions who meet intermediate facility for mental retardation level of care.



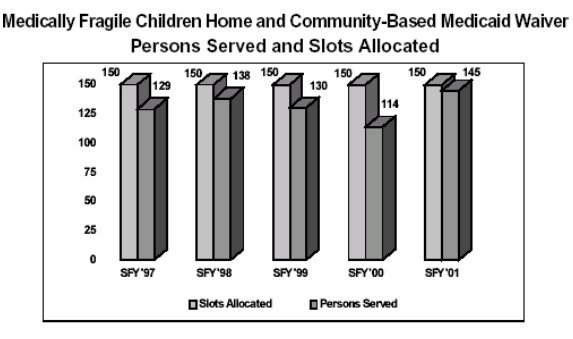


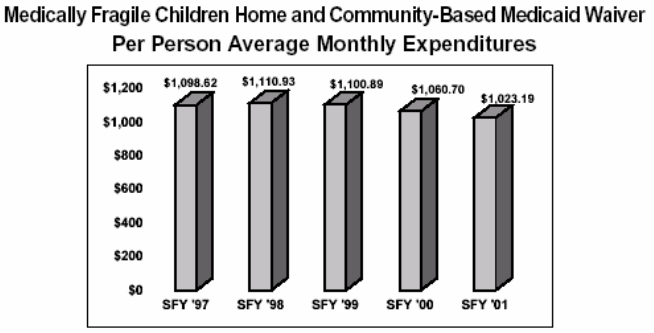
SFY 2000 Medicaid Payments for ICF/MR [Table 9]

	Number of Unduplicated Residents	Total Payments	Annual Cost Per Resident
Group Home ICF/MR	4,176	$199,873,533	$47,862
Large Private ICF/MR	1,064	$36,995,193	$34,770
State ICF/MR	523	$52,350,946	$100,097

iv. ***Medically Fragile Children Waiver***

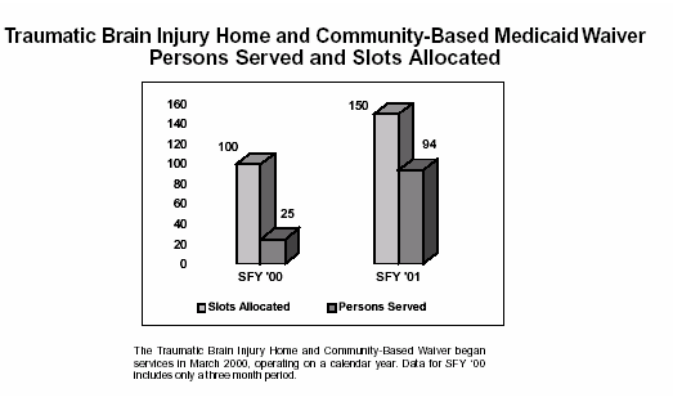
This waiver serves children under 18 years of age who are in need of significant medical services, including those who are technologically dependent. Beneficiaries of these services meet either skilled nursing facility level of care or hospital level of care.

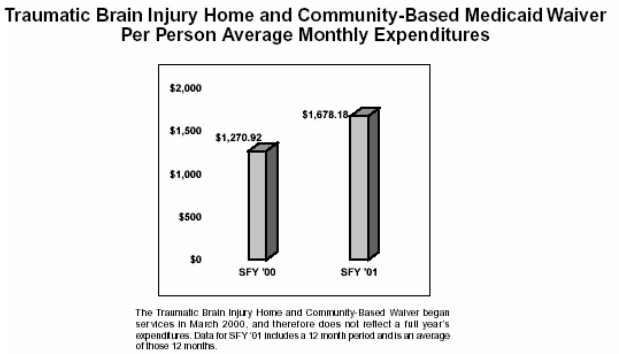




v. ***Traumatic Brain Injury Waiver (TBI)***

The TBI waiver serves persons who have suffered injuries to the brain including closed or open head injuries. Services under this waiver were implemented in March 2000.



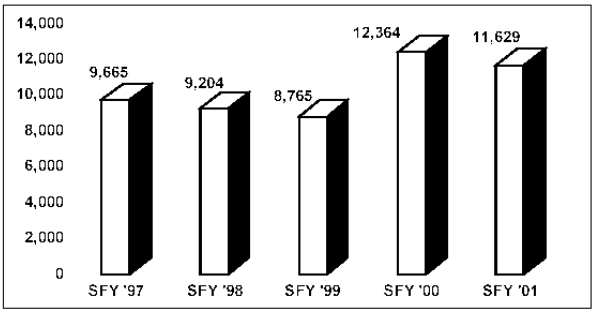


B. Adult Protective Services

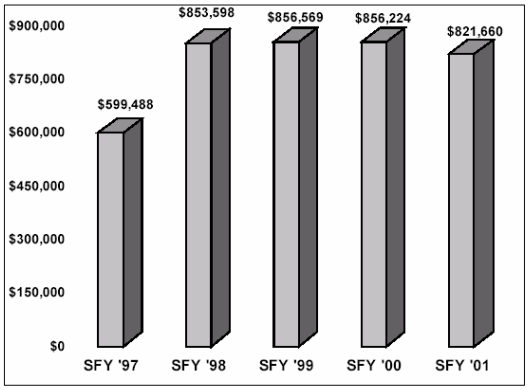
The purpose of the Adult Protective Services Program is to provide protection to adults who are endangered by abuse, neglect, or exploitation. The law defines "endangered adults" as individuals at least 18 years of age, incapable of caring for themselves, and being abused, neglected, or exploited.

Adult Protective Services served 11,629 Hoosiers in State Fiscal Year 2001. Program expenditures for that period were $821,660.

Adult Protective Services
Persons Served Per Year



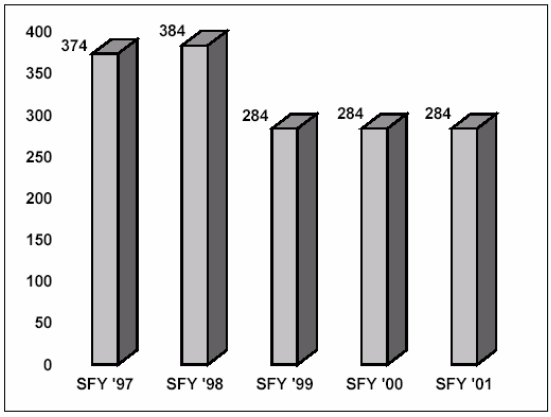
Adult Protective Services
Trend of Annual Expenditures



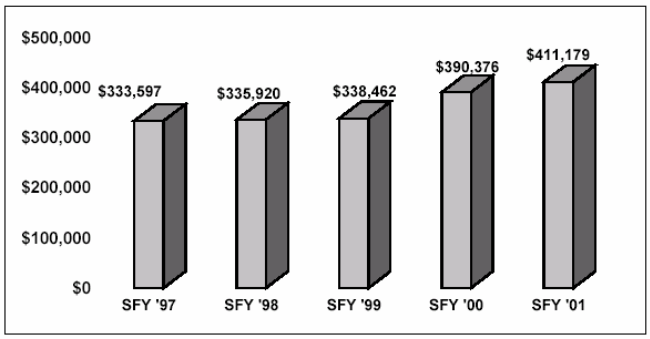
C. The Adult Guardianship (AGS) Program

This program was established to provide full guardianships, limited guardianships, and less restrictive alternative services to indigent, incapacitated, adults who are unable to care for themselves and/or manage their own affairs without assistance, or who have a developmental disability. The AGS Program served 284 individuals in SFY 2001. Total expenditures for that period were $335,920.

Adult Guardianship Services Program
Persons Served Per Year*



Adult Guardianship Services Program
Trend of Annual Expenditures*



* Persons served per year reflects Adult Guardianship services that are funded with multiple resources, while trend of annual expenditures reflects only state funding. The reductions in persons served per year is primarily a function of changes in non-state funding, as state funding has increased in recent years.

D. Child Welfare Rehabilitation Option (CWRO)

The Child Welfare Rehabilitation Option is a new Medicaid waiver option that will provide clinical mental health services to individuals living in the community or in Residential Treatment Facilities who need aid intermittently or on a twenty-four hour a day basis for emotional disturbances or mental illness. Medicaid reimbursement will be available to current DFR licensed facilities and licensed child-placing agencies (LCPA). Indiana is requesting this option in order to leverage federal dollars. Currently, the costs of these services are being paid with 100% county funds. This waiver should be available sometime in CY 2003.

E. Child Support

The Bureau of Child Support assists Hoosier families and children by enforcing parental responsibility through collection of payments by non-custodial parents. The child support program provides a full range of child support services, including establishment of paternity, establishment and enforcement of child support orders, collection and distribution of child support payments, and location of absent parents.

Every child has the right to the care and support of both parents, regardless of whether or not the parents are married or both in the home. The child support program enforces this right. Child support services are offered through County Prosecutors Offices (one in each of the 92 Indiana counties.)

These services include:
- Locating absent parents
- Establishing paternity
- Establishing and enforcing support orders
- Establishing and enforcing medical support orders
- Collecting current and past due support payments
- Review and adjustment of current support orders

F. Food Stamps

Indiana's Food Stamp Program is designed to raise the nutritional level of low-income households by supplementing their available food purchasing dollars with food stamp benefits. Information regarding nutrition and budgeting is available to participants to assist in choosing a nutritionally sound diet with limited income. Program participants are entitled to use their food stamp benefits at the retailer of their choice and choose foods based on their own preferences. However, retailers must be federally approved to accept food stamp benefits. Non-food items may not be legally purchased with food stamp benefits.

The Food Stamp Program is administered through each state but benefits are funded solely by federal funds. Federal regulations which govern implementation of the program are developed by the United States Department of Agriculture, Food and Nutrition Services section pursuant to federal legislation. In Indiana, the Family and Social Services Administration is responsible for ensuring that these federal regulations are initially implemented and consistently applied in each county.

The local Office of the Division of Family Resources in each of the ninety-two Indiana counties has the responsibility for processing applications, certifying eligible applicants for participation, and issuing benefits.

In order to qualify for food stamp benefits, applicants/participants must meet both non-financial and financial requirements. Non-financial requirements include state residency, citizenship/alien status, work registration, and cooperation with the IMPACT Program. The financial criteria are income and asset limits. If an applicant is eligible based on the federally established financial and non-financial requirements, the allotment of food stamp benefits they receive is based on household size and net monthly income after all allowable deductions are subtracted.

The asset/resource limits are $2,000 per household except for households containing a member age 60 or older; then the limit is $3,000. Assets include bank accounts, cash, real estate, personal property, vehicles, etc. The household's home and surrounding lot, household good and personal belongings and life insurance policies are not counted as assets in the Food Stamp Program. All vehicles used for transportation were exempt effective March 1, 2002.

All households must pass a gross income test of 130 percent of the federal poverty level to qualify for benefits with the exception of those with elderly or disabled members. The gross income is determined by household size and based on the gross monthly income received by all household members.

Totals – Persons 331,206; Total dollars 297,964,712 (SFY 2001.)

G. Family Protection and Preservation

FSSA's Bureau of Family Protection and Preservation (BFPP) and The Department of Child Services local offices serve children in the state who are at risk of abuse or neglect. The BFPP administers programs that provide child welfare and family services, child abuse prevention services, foster care, adoption, independent living, residential licensing and youth services. The BFPP provides child protection services to protect Indiana's children from further abuse or neglect and prevents, remedies, or assists in solving problems that may result in neglect, abuse, exploitation, or delinquency of children.

The Family Preservation Program carries out the Department's goal to prevent unnecessary separation of children from their families by identifying family problems while assisting families in resolving them.

The program also seeks to return children who have been removed from their homes to their families through the provision of services to the child and family problems while assisting families in resolving them.

The program also seeks to return children who have been removed from their homes to their families through the provision of services to the child and family when a court finds that reunification is in a child's best interest.

The Family Preservation Program provides services to prevent out-of-home placement or to reunify children and their families in cases of substantiated reports of child abuse or neglect. Program services offered to families include education, counseling, visitation, sexual abuse treatment, parent aides, homemaker services, and home-based family services.

Statistics show that approximately 12,500 children and their families are separated at any given time. The State of Indiana has developed a five-year plan for family preservation and support services with the help of local Step Ahead councils and local service needs assessments. Federal Title IVB Part II monies fund the five-year plan.

Children in Need of Services (CHINS) By Type of Placement

	Total CHINS	Foster Homes	Residential Care	Adoptive Homes	Own Home	Relative Home	Other
March 2003	10,793	4,320	1,391	0	2,968	909	1,205
March 2002	9,981	4,109	1,315	12	2,594	850	1,101
% Incr (Decr)	8.1	5.1	5.7	(100)	14.4	6.9	3.4

CY 2002 Identified CHINS Costs

(Family & Children Fund)

Foster Homes Relative	4,239,002
Foster Homes Non Relative	24,820,858
Therapeutic Foster Homes	42,488,278
Residential Facilities	101,635,371
Independent Living	367,603
Preservation Services	15,901,499
Misc. Cost	6,174,904
Total CHINS	**195,627,515**

As reflected in the table above, the cost of care for children in out-of-home placement is much greater than the cost of providing care to children at home. For example, in March 2002, nearly twice as many Children in Need of Services (CHINS) were being served in their own homes compared to being served in residential facilities. The annual cost for residential facilities care in 2002 was more than six times greater than that of preservation services.

Family preservation expenditures largely reflect the cost of home and community-based services to children and their families who are under the supervision of the local office of family and children (court) and have been placed in their own homes. However, some of these costs are spent on home and community-based services to families of children who have not yet been returned home. The purpose of these services is to prepare the family for the return of the child.

Child Welfare Expenditures, 2000 (Actual) to 2003 (Budgeted)

	2000	2001	2002	2003
Community Based				**Division**
Family & Children Fund - Cal. Year	**Actual**	**Actual**	**Final**	**Approved**
Foster Homes	34,617,916	32,222,819	37,579,584	35,575,384
Therapeutic Foster Homes	40,090,952	42,304,579	46,998,682	48,279,729
Independent Living	388,420	438,367	919,010	1,085,027
Preservation Services	34,886,060	38,283,145	42,480,974	42,879,185
MRO	783,373	1,060,782	2,088,999	2,248,177
Adoption Services	36,531,177	45,597,986	51,257,395	59,407,342
Child Welfare Services (CWS)	6,322,682	6,597,595	9,266,490	8,923,470
Destitute Children	20,063	11,696	Included in CWS	Included in CWS
Contracted with the State - FFY	**Actual**	**Actual**	**Actual**	**Budgeted**
IV-E, Independent Living	928,348	573,364	1,438,383	2,088,263 *
IV-B, Part I (Services Only)	$6,479,168	5,837,145	5,439,221	8,977,352 *
IV-B, Part II	3,449,171	3,410,345	2,674,202	7,819,282 *
Institutional Placements				**Division**
Family & Children Fund - Cal. Year	**Actual**	**Actual**	**Final**	**Approved**
Wards in Institutions	160,076,123	154,590,406	163,255,134	186,082,668
Prevention	**Actual**	**Actual**	**Actual**	**Budget**
Healthy Families	27,563,895	35,841,092	41,132,458	40,855,489
First Steps	31,428,952	54,078,028	58,930,670	63,729,758

* These budgeted amounts include prior-year carry forward.

H. First Steps Program

The First Steps Early Intervention System is Indiana's response to Part C of the Individuals with Disabilities Education Act. First Steps' broad definition of children with special needs, the exclusion of family income as consideration for eligibility, emphasis on family-focused intervention and efforts to provide services in the child's natural environment combine to create a successful program whose population consists of those most in need of early intervention.

First Steps is based in each of Indiana's 92 counties and is implemented by a Local Planning Coordination Council in each of them. In SFY 2001, 16,272 infants and toddlers received services through the First Steps System. The estimated number of First Steps population is 18,000 children.

The program is available to children from birth to three years old who:

- Are experiencing developmental delay;

- Have a diagnosed condition that has a high probability of resulting in a developmental delay; and/or
- Are at risk of having substantial developmental delay as a result of biological risk factors if early intervention services are not provided.

Services available include the following:

- Speech therapy
- Occupational therapy
- Physical Therapy
- Developmental Therapy
- Social Work
- Psychological service
- Nutrition
- Health
- Nursing
- Medical Diagnostics
- Audiology
- Vision Services
- Assistive Technology
- Service Coordination
- Transportation
- Family Training
- Counseling

SFY 2002 First Steps expenditures from all funding sources:

First Steps Early Intervention Services (Part C Grant 2001)	$7,830,010
Early Intervention (other sources)	$52,809,390

I. Healthy Families

Healthy Families Indiana is a primary prevention program. It is a voluntary home visiting program for new parents as well as strategy for strengthening families and promoting healthy child outcomes. A variety of services are provided including child development, access to health care and parent education. By working closely with hospital maternity wards, prenatal clinics, and other local agencies, the program systematically identifies, either before or immediately after birth, families who would benefit from education and support services and offer them home visitor services. In partnership with Healthy Families America, the national home visitation model, Healthy Families Indiana was launched in 1994. Prevent Child Abuse America and Healthy Families America credentialed Healthy Families Indiana as a multi-site system on September 25, 2001.

Indiana has the first Healthy Families program in the nation to support a state system with blended federal funds through the establishment of a Healthy Families Fund. Indiana is also the first state to establish formal linkages with the U.S. Justice Department.

At the state level, four revenue sources contribute to the overall funding: Children's Trust Fund, Indiana Criminal Justice Institute, FSSA Division of Mental Health and Addictions, and TANF funding through the FSSA Division of Family Resources.

The program is designed to strengthen families by reducing the incidence and possibility of child abuse and neglect, childhood health problems and juvenile delinquency. The goals of Healthy Families Indiana are to systematically identify overburdened families; promote healthy family functioning by teaching problem solving skills; reduce family stress; improve family support systems; promote positive parent/child interaction; promote health childhood development; prevent child abuse and neglect; and promote self sufficiency by linking families to existing community resources.

Healthy Families Indiana provides screening and assessment of families in targeted areas throughout the state. Service entry points include WIC programs, health clinics and local hospitals. Parents are screened using a validated, standardized instrument, and the Maternal Record Screen. Positive screens do not assess the risk of child abuse and neglect but do indicate a need to conduct a more in-depth discussion with the family.

Families with positive screens are then assessed using a standard validated instrument, the Kempe Family Stress Checklist which is scored using a standardized rating scale. Families with a score of 25 or higher are offered the opportunity to participate in a voluntary home visiting program tailored to their individual needs.

The 56 Healthy Families Indiana program sites provide services to families throughout the state. The number of families served has increased from 760 in 1994 to 21,401 in 2001. Healthy Families has grown from a $600,000 child abuse and neglect program in 1994 to $40.5 million in 2001. Funding is a combination of local, state, and federal dollars.

Descriptive data provided by Healthy Families Indiana sites during 2000 - 2001 have revealed the following results:

- Of the 4,000 families screened each month, 45% had a positive screen and nearly 20% had a positive assessment;
- 90% of the children had a regular primary health care provider and over 70% kept regularly scheduled well child visits;
- 75% received age appropriate Denver II Developmental Screenings and 80% were up to date on childhood immunizations;
- 3% of the families experienced a subsequent pregnancy;
- 28% of mothers who have not graduated from high school are enrolled in school or a GED program; and
- Over 98% of the families served in the largest Indiana site that had at least 24 home visits had no substantiated abuse or neglect while in the program despite the fact they were at higher risk.

J. Other Pertinent Services

- In State Fiscal Year 2001, more than 1.4 million congregate and 1.4 million home delivered meals were provided in Indiana.[xxix]

- Furthermore, $9 million was spent on Room and Board Assistance and $2.7 million was spent on Assistance to Residents of County Homes.

FY 2000 Profile of Indiana Older American Act Programs[xxx]		
Title III/VII Services	**60+ Persons Served**	**Service Units**
Personal Care	892	65,611
Homemaker	6,273	212,353
Chore	1,705	35,723
Home Delivered Meals	27,781	3,160,258
Adult Day Care/Health	457	150,196
Case Management	43,537	185,162
Congregate Meals	41,325	2,427,756
Nutrition Counseling	3,873	22,985
Assisted Transportation	7,673	187,633
Transportation		1,321,712
Legal Assistance		24,543
Nutrition Education		88,018
Information and Assistance		250,635
Outreach		527,357

SECTION V: GLOSSARY OF TERMS, ACRONYMS, AND RELEVANT AGENCIES

AAA

Area Agencies on Aging – (also known as Area Agencies or Triple A) Sixteen nonprofit agencies located throughout the state which provide services, and grant or contract with other public and private organizations to provide services, for older persons within their area. In Indiana, they are responsible for administering federal and state funding for community and in-home long term care services for the aged and disabled.

ACT

Assertive Community Treatment - a very intensive case management approach for high-risk individuals with severe mental illnesses. The model for ACT involves maintaining housing, living independently, home visits, and medication management assistance by trained staff.

ADA

Americans with Disabilities Act **-** Enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

ADLs

Activities of Daily Living – A measurement of a person's degree of independence in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also see "Custodial Care."

Adult Day Care or Adult Day Care Services

Care generally offered by a social service agency or nursing home, usually custodial care in nature. Similar in concept to children's day care centers but catering to adult needs and interests.

Adult Protective Services

Investigates and resolve reports of abuse, neglect, or exploitation, and to assist in obtaining protective services for endangered adults.

AOA

Administration on Aging – A federal agency under the U.S. Department of Health and Human Services. AOA provides home and community-based services to older persons through the programs funded under the Older Americans Act. Programs include home-delivered meal programs, nutrition services in congregate settings, transportation, adult day care, legal assistance, ombudsman services and health promotion programs.

Assisted Living Facility

Provides home and community services in a more home-like and comfortable environment than the typical nursing home setting. Services are designed around the resident's needs. Provides a combination of social interaction and privacy. Nursing staff provide nursing services in licensed assisted living facilities. These services are provided by a home care agency in unlicensed assisted living facilities.

Assistive Technology

Assistive technology device means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Assistive technology service means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

Benefit Period

The period of time for which the insured is eligible to receive benefits or services under Medicare, Medicare Supplement, or a Long Term Care insurance policy.

Benefit Period under Medicare

The Medicare Part A benefit period begins upon entry to a qualified hospital, and ends when the patient has been out of a hospital (and not receiving Medicare benefits in a facility that primarily provides skilled nursing or rehabilitation services) for 60 consecutive days, including the day of discharge. The Part B benefit period is based on the calendar year.

Medicare Part A can cover inpatient hospital care, skilled nursing facility care, home health care and hospice care. Medicare Part B includes a wide range of services including outpatient hospital services (e.g. radiology and laboratory tests, therapy services, medical supplies, and durable medical equipment), physician services and home health care. In a skilled nursing facility (following a qualified hospital stay), Medicare Part A will pay in full for Day 1- 20 and for Days 21- 100 a co-insurance amount of $101.50 per day in 2002 is required. A beneficiary qualifies for a new 100-day benefit period when there are 60 days during which there has been no inpatient stay, no Medicare SNF stay, and no inpatient care for a continued skilled level of care. The Part B benefit period covers specific services based on the calendar year.

BI or TBI

Brain Injury or Traumatic Brain Injury– There are currently 5.3 million Americans living with a disability caused by brain injury. Brain injury is acquired damage to the brain, the result of either an external physical force or internal causes, which results in an impairment of cognitive, emotional, and/or physical functioning. It is not of a degenerative or congenital nature but caused by an external physical force or by internal damage such as anoxia (lack of oxygen), stroke, disease, or tumor. It may produce a diminished or altered state of consciousness, which results in impairment of "thinking processes" and physical abilities. These impairments may be either temporary or permanent, and cause partial or total functional disability or psychosocial maladjustment.

BAIHS

Bureau of Aging and In-Home Services- a part of Family and Social Services Administration/ DDARS. BAIHS administers four Medicaid waivers, CHOICE, and other home and community-based services for people who have disabilities or are aging.

BDDS

Bureau of Developmental Disabilities Services- a part of Family and Social Services Administration/ DDARS that administers developmental disabilities services programs, including three Medicaid waivers.

Case Manager

An individual qualified by training and/or experience to coordinate the overall medical, personal, and social service needs of the patient. Someone who coordinates/manages the patient's care or "case."

Case Management

The coordination and monitoring of treatment and services.

CHOICE

Community and Home Options to Institutional Care for the Elderly and Disabled – One of Indiana's in-home services programs administered by the sixteen Area Agencies on Aging.

CMHC

Community Mental Health Centers- state, local, or non-profit entities. They are contracted by the Indiana Division of Mental Health to provide a full range of mental health services within a designated geographical area. They also provide a "gatekeeper" function to monitor each individual from the time the individual was committed to a state institution administered by the division until the individual is discharged from the commitment. The provide services regardless of a client's ability to pay.

CMS

Centers for Medicare and Medicaid Services – A branch of the Department of Health and Human Services. This federal agency is responsible for administering the Medicare and Medicaid programs and approves all waivers and waiver amendments. Formerly HCFA (Health Care Financing Administration).

Convalescent Care/Rehabilitative Care

Non-acute care prescribed by a physician and received during the period of recovery from an illness or injury.

Conversion

For the purpose of the Medicaid waiver, the closing of a Medicaid funded facility or a portion of the facility, and the conversion of the facility's bed capacity to Medicaid waivers. The facility must have a closure or downsizing plan approved by the state in order to allow the funding to follow the person into the community. Also refers to the "systems change" of community rehabilitation programs from the provision of segregated services, i.e. sheltered workshops, to integrated services, i.e. supporting people in competitive employment in the community

CPS

Child Protective Services –Protects Indian's children from further abuse or neglect and prevents, remedies, or assists in solving problems that may result in abuse, neglect, exploitation, or delinquency of children.

Custodial Care

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Example: help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living or ADLs.)

CWRO

Child Welfare Rehabilitation Option – New Medicaid waiver option that will provide clinical mental health services to individuals living in the community or in Residential Treatment Facilities. Recipients will be those who need aid intermittently or on a twenty-four hour a day basis for emotional disturbances or mental illness. This option is being sought to leverage federal dollars to cover the cost of services that are currently being paid with 100% county funds. Waiver should be available sometime in CY 2003.

DAPW

Division of Public Works (http://www.in.gov/idoa/pwd/)- As a key branch of the Indiana Department of Administration (IDOA), the Public Works Division (DAPW) manages almost all of the building construction and maintenance projects for the State of Indiana. This includes evaluation of construction proposals for feasibility; designing the projects; advertising, public bids, and awarding construction; and managing these construction contracts through final completion. In past years, DAPW has administered more than 1000 design and construction projects annually, with an average estimated value in excess of $70,000,000.

DDARS

Division of Disability, Aging and Rehabilitative Services – a part of Family and Social Services Administration. Includes Bureau of Aging and In-Home Services, Bureau of Developmental Disabilities Services, Bureau of Rehabilitative Services, Bureau of Fiscal Services and the Bureau of Quality Improvement Services.

DD

Developmentally Disabled **-** A developmental disability is distinguished from other disabling conditions in that it occurs during the developmental years of an individual's life, usually before the

age of 18. Although the federal law does not define specific disabling conditions, persons with mental retardation or autism are generally developmentally disabled. Persons diagnosed as having a condition such as moderate or severe cerebral palsy may also be considered developmentally disabled. In addition, the 10- 15 percent of those persons with epilepsy who experience uncontrolled seizures also fit the definition of developmentally disabled.

DFR/DCS

Division of Family Resources/Department of Child Services – A state agency that strengthens families through services that focus on prevention, early intervention, self-sufficiency, family support and preservation. The division administers child welfare, Food Stamps, employment and training services for low-income clients and Medicaid eligibility.

DHHS

Department of Health and Human Services – The federal agency that administers the Medicare Program through its divisions, the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) – previously HCFA.

DME

Durable Medical Equipment – this is equipment which can: 1) withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of an illness or injury; and 4) is appropriate for use in the home.

DMHA

Division of Mental Health and Addiction **– Division of the Indiana Family and Social Services Administration.**

DOE

Department of Education

DOE/ DEL

The Division of Exceptional Learners, Indiana Department of Education- administers the Individuals with Disabilities Education Act (IDEA, P.L. 101-476), which applies to students with disabilities, ages 3 through 21, in Indiana. Included in this Act are students with autism, deaf-blindness, deafness, hearing impairments, mental impairments, multiple disabilities, orthopedic impairments, other health impairments, emotional handicaps, learning disabilities, communication disorders, traumatic brain injury, and visual impairments.

DOH or ISDH

Department of Health or Indiana State Department of Health (http://www.in.gov/isdh/index.htm) agency which serves to promote, protect, and provide for the public health of people in Indiana.

DOI

Department of Insurance (http://www.in.gov/idoi/)- agency which enforces statutes and regulations applicable to the operation of approximately 1,780 insurance companies, the issuance of insurance policies, the handling of complaints, and the dissemination of public insurance information. The Department, headed by a commissioner appointed by the governor, employs approximately 80 persons.

Deinstitutionalization

Policy which describes the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

Disability

Any limitation of physical, mental or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual major activities, most commonly vocation. There are varying types (functional, vocational, learning), degrees (partial,

total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.

Dually Diagnosed

Dual Diagnosis is a term applied to the co-existence of the symptoms of both mental retardation and mental illness.

Endangered Adult

Individuals who are at least 18 years of age, incapable of caring for themselves, and being abused, neglected, or exploited.

FSSA

The Family and Social Services Administration (http://www.in.gov/fssa/)- an agency of the State of Indiana providing services to families who have issues associated with:

- low income,
- mental illness,
- addiction,
- mental retardation,
- a disability,
- aging, and
- children who are at risk for healthy development.

First Steps

A coordinated system of statewide local interagency councils whose mission it is to assure that all Indiana families with infants and toddlers experiencing developmental delays or disabilities have access to early intervention services close to home when they need them.

Group Home

A Group Home is a residential facility for a group that requires special care or supervision, such as children, mentally ill, senior citizens, or troubled teens or persons.

Health Professions Bureau

(http://www.in.gov/hpb/) Provides professional, quality support services to Indiana's health regulatory boards and committees, in furtherance of their responsibility to assure the safe and competent delivery of health care to the citizens of Indiana.

Healthy Families

A voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care, and parent education.

Home Health Care Agency

A home health care agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Care

Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home health care only if the type of care needed is skilled and required on an intermittent or part-time basis, and is intended to help people recover or improve from an illness or injury.

Hoosier Healthwise

A health insurance program for Indiana children, pregnant women, and low-income families. Health care is provided at little or no cost to Indiana families enrolled in the program.

HoosierRx

Indiana's prescription drug program for low-income seniors. Any eligible senior enrolled in the HoosierRx Program will receive 50% of the cost of their medications, up to a yearly benefit cap.

ICF/MR

Intermediate Care Facility for the Mentally Retarded– A facility in which individuals with developmental disabilities live together. There is 24-hour supervision by paid staff who provide assistance and training to help residents develop daily living skills, with programming for each individual's needs. These residences may be large, state or privately operated facilities, or group homes for 4 to 8 residents.

IDOL

Indiana Department of Labor (http://www.in.gov/labor/)- agency seeks to promote the welfare of Indiana's workforce by administering a variety of educational and compliance programs designed to provide the knowledge and tools necessary to guarantee workers' rights to safe, healthful, positive work environments, and the appropriate compensation for that work.

IHFA

Indiana Housing Finance Authority (http://www.in.gov/ihfa/)- created in 1978 by the Indiana General Assembly, it is a state-operated bank that finances residential mortgages and the development of rental housing. In addition, it is also a community development organization. IHFA provides affordable homes for Hoosiers, stimulates the construction industry and construction employment, and is financially self-sufficient. No state taxes are used for operating support of IHFA.

IHSS

In-Home Supportive Services –Non-medical services to help functionally impaired persons of all ages, with limited resources, stay at home. (For those who qualify, it is paid by Title XX of the Social Security Act.)

IMPACT

The Indiana Manpower & Comprehensive Training service- Provides job-related services to help TANF and Food Stamp recipients become economically self-sufficient.

INDOT

Indiana Department of Transportation (http://www.in.gov/dot/)- the agency's mission is to provide our customers the best transportation system that enhances mobility, stimulates economic growth, and integrates safety, efficiency and environmental sensitivity.

Independent Living Services

Promotes a philosophy of independent living including consumer control, peer support, self help, self determination, equal access, and individual and system advocacy, to maximize the integration and full inclusion of individuals with disabilities, community leadership, empowerment, independence, and productivity.

Institutionalization

Admission of an individual to an institution, such as a nursing home, for an extended period of time or indefinitely.

Intermediary or Fiscal Intermediary

An organization that handles Part A (*see definition*) claims submitted by hospitals, skilled nursing facilities, home health agencies, hospices, and other providers of services.

Intermittent Care

Not daily care, but care done on a part time basis.

IPAS

Indiana Protection and Advocacy Services (http://www.in.gov/ipas/)- Mission is "to protect and promote the rights of individuals with disabilities, through empowerment and advocacy."

- May be able to assist citizens of Indiana who have a disability and are either being denied a right or are being discriminated against because of that disability.
- Administers 6 Federally Mandated and Funded Programs for Indiana
  - Client Assistance Program (CAP)
  - Protection and Advocacy for Assistive Technology (PAAT)
  - Protection and Advocacy for Beneficiaries of Social Security (PABSS)
  - Protection and Advocacy for Individuals with Developmental Disabilities (PADD)
  - Protection and Advocacy for Individuals with Mental Illness (PAIMI)
  - Protection and Advocacy for Individual Rights (PAIR)
- Is an Independent State Agency which receives no state funding and is Independent from all service providers.
- As required by federal law and state law, must be and is independent of state governmental control.
- Is governed by the 13-member IPAS Commission which sets the agency's Priorities.
- Is advised on Mental Illness matters by a 10-member Advisory Council (MIAC).

Kids at Risk

Children who are “at risk” of failing to succeed in life because of the adversities of their young lives. Poverty, family discord, violence and abuse, substance abuse, and illness are among the hazards.

Lifetime Reserve Days

Sixty extra days provided by Medicare hospital insurance (Part A) that can be used in case of a long illness where the stay in the hospital is more that 90 days. Reserve days are not renewable – they can only be used once. A co-payment is required.

Long Term Care Insurance

A policy designed to help alleviate some of the costs associated with long term care, such as nursing home or home health care costs.

LTC

Long Term Care – the medical and social care given to individuals with impairments covering a long period of time. Long term care can consist of care in the home by family members, assisted with voluntary or employed help (such as provided by home healthcare agencies), adult day care, or care in institutions.

Medicaid

A federal-state partnership designed to ensure that the United States’ aged, sick, and impoverished are cared for. This program, authorized by Title XIX of the Social Security Act, is a safety net that provides aid in the form of medical services to people who fall below the state-established poverty line. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods for administering the program.

Medically Necessary

Medical necessity must be established (through diagnostic and/or other information presented on the claim under consideration) before Medicare or the insurance company will make payment

Medically Needy

Persons who are categorically eligible for Medicaid and whose income, less accumulated medical bills, is below state income limits for the Medicaid program (see Spend Down).

Medicare Part A

This provides either total or partial overage for hospital care, skilled nursing facility care, home health care services, and hospice services.

Medicare Part B

This covers a portion of the costs for doctors' care; physical, occupational and speech therapy sessions; ambulance services; prostheses; medical equipment; and home health services.

M.E.D. Works

Medicaid for Employees with Disabilities- allows disabled working individuals with incomes too high for regular Medicaid to be eligible for health coverage. M.E.D. Works members whose income is more than 150% of the federal poverty level will be charged a premium on a sliding-fee scale based on income. These individuals will receive the full-range of traditional Medicaid-covered services and will pay the same co-payments for certain services. This law was passed by the Indiana Legislature in 2001.

MI

Mental Illness - Mental illnesses are disorders of the brain that disrupt a person's thinking, feeling, moods, and ability to relate to others. Mental illnesses are disorders of the brain that often result in a diminished capacity for coping with the ordinary demands of life.

MR

Mentally Retarded – This is a disorder in which a person's overall intellectual functioning is well below average, with an intelligence quotient (IQ) around 70 or less. Individuals with mental retardation also have a significantly impaired ability to cope with common life demands and lack some daily living skills expected of people in their age group and culture. The impairment may interfere with learning, communication, self-care, independent living, social interaction, play, work, and safety. Mental retardation appears in childhood, before age 18 and affects approximately 1-2% of the population.

Nursing Home

A place where persons reside who need some level of medical assistance and/or assistance with activities of daily living. Not all nursing homes are Medicare or Medicaid approved/certified facilities.

Nursing Home Policy

Type of health insurance policy which generally pays indemnity benefits for medically necessary stays in nursing homes (sometimes referred to as Long Term Care policies).

OAA

Older Americans Act – Federal legislation enacted in 1965 to provide money for programs and direction for a multitude of services designed to enrich the lives of senior citizens. Example adequate housing, income, employment, nutrition, and health care.

OBRA

Omnibus Budget Reconciliation Act

Occupational Therapy

Therapy by means of work (i.e., arts and crafts) designed to divert the mind, to correct a particular physical defect, or to equip a handicapped patient with new skills.

OMPP

Office of Medicaid Policy and Planning– part of the Family and Social Services Administration. Determines level of care of Intermediate Care Facilities for the Mentally Retarded (ICF/MR), waivers, and nursing homes. It is responsible to CMS for oversight of the Medicaid waiver program.

Olmstead Decision

The Olmstead decision issued in 1999 interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Medicaid is the main resource in helping states to meet these goals. However, the scope of the ADA and the Olmstead decision are not limited to Medicaid beneficiaries or to services financed by the Medicaid program. The ADA and the Olmstead decision apply to all qualified individuals with disabilities regardless of age

Ombudsman

A "citizens' representative" who protects a person's rights through advocacy, providing information, and encouraging institutions or agencies to respect citizens' rights. Two programs: DD Ombudsman and Aging Ombudsman.

Per Diem

Per day, or a daily charge.

Personal Care

Assistance provided to people who need help with bathing, cooking, dressing, eating, grooming or personal hygiene. These service are not routinely paid for by either Medicare of Medicaid, but for those who qualify may be paid for by IHSS.

PPS

Prospective Payment System – Under PPS, nursing facilities are paid fixed amounts based on the Resource Utilization Group (RUG) for the person based on their relative staff and resource needed and acuity. In some cases, the Medicare payment will be more than the actual cost of providing services for that stay. In other cases, the payment will be less than the nursing facility's actual cost.

Provider

A generic term describing any individual, organization or company enrolled to provide services. Qualifications vary depending on the type of service provided.

Psychiatric Hospital Care

Medicare Part A can help pay for no more than 190 days of care in your lifetime in a participating psychiatric hospital.

Reasonable and Necessary Care

The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Rehabilitation

The coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disable by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical and educational.

RCAP

Residential Care Assistance Programs- State program that pays for care provided in licensed residential care facilities (assisted living) and in county homes for low income persons needing this level of care.

Respite Care

Short term care given to a person(s) with and illness or disability in the home, nursing home, or hospital; intended to give relief to the principal caretakers.

Sheltered Workshop

A segregated setting in which persons with disabilities who are not capable, temporarily or permanently, of competitive employment in the community are provided with vocational, pre-vocational, and habilitative services and experience.

Skilled Nursing Care

Care which can only be provided by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility

A Medicare participating nursing facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services, and other related health services for which Medicare pays benefits.

Social Security Administration

This federal agency is responsible for the Medicare enrollment process, for determining Medicare eligibility, and for SSI and SSDI benefits.

Social Security Benefits

Benefits payable under Social Security programs, can be assigned to three general categories – retirement benefits, survivor benefits, and disability benefits.

Spend Down

1) A process of becoming eligible for Medicaid nursing home assistance by exhausting one's assets to pay for their care, until Medicaid asset eligibility is established. 2) A process of becoming eligible for Medicaid at home **or nursing home** assistance by paying for medical care out of one's own income, until Medicaid income eligibility is established. This occurs on a monthly basis, after asset eligibility is met on the 1st day of the month.

Spousal Impoverishment Provision

The community property and assets of a nursing home resident who is married may be divided to protect the property and assets of the spouse not in the nursing home.

State Budget Agency

(http://www.in.gov/sba/agencyinfo/)- the **a**gency's mission is to achieve excellence in fiscal decision making and fiscal results on behalf of the Governor and in support of the General Assembly. The State Budget Agency facilitates the processes of revenue forecasting, budget development, and budget implementation. The Budget Agency evaluates and communicates the fiscal and policy impacts of legislative proposals with the objective of assuring best information available to decision makers.

State Fiscal Year

The state fiscal year for the state of Indiana begins on July 1st and ends on June 30th of the next year.

Supported Employment

Individuals with the most severe disabilities are placed in competitive jobs with qualified job coaches/trainers to provide individualized, ongoing support services needed for each individual to retain employment. The employee is contacted monthly, either at or away from the workplace, to address any issues that may threaten the individual's ability to remain on the job.

Ticket to Work

The Ticket to Work and Work Incentives Improvement Act of 1999 provides States with three opportunities to assist disabled persons to maintain employment: grants to States to develop the administrative and internal structures in their Medicaid programs necessary to support people with disabilities who are employed; a demonstration to provide health care benefits to employed individuals with potentially disabling conditions; and two new opportunities to use federal matching funds for providing Medicaid benefits to working disabled.

Title XVIII

The portion of the Social Security Act which clearly defines the provisions of Medicare.

Title XIX

The portion of the Social Security Act which clearly defines the provisions of Medicaid.

Vocational Rehabilitation

Provides comprehensive, coordinated, effective, efficient, and accountable services needed by eligible individuals with disabilities to prepare for, enter, engage in, and retain employment consistent with each individual's strengths, resources, priorities, concerns, abilities, capabilities, and informed choice.

VRS

Vocational Rehabilitation Services- Vocational Rehabilitation Services (VRS) assists eligible people with disabilities to achieve employment and independence. VRS is committed to securing quality individualized services which enable individuals with disabilities, including individuals with the most severe disabilities, to pursue meaningful careers by obtaining gainful employment consistent with their abilities and capabilities.

VRS customers have the responsibility to participate in their own rehabilitation program, including making meaningful and informed choices about the selection of the employment outcome, vocational objectives, and vocational rehabilitation providers. Each VRS customer works in partnership with his or her vocational rehabilitation counselor who provides on-going rehabilitation counseling, case management, and follow up through each phase of the process of vocational rehabilitation.

To be eligible to participate in the VRS program, an individual must have a physical or mental disability, which results in a substantial impediment to employment, and the individual must require services to prepare for, enter into, engage in, or retain gainful employment. Services provided by VRS must be directly linked to an employment outcome, and must be necessary for an individual to perform the basic duties of a job.

Waiver

The Medicaid Wavier programs are funded with both State and Federal dollars. All waiver programs have been initiated by the Indiana General Assembly and approved by the CMS.

Eligibility for all waiver programs requires:

- The recipient must meet Medicaid guidelines.
- The recipient would require institutionalization in the absence of the waiver and/or other home-based services.
- The total aggregate Medicaid cost of serving the recipient(s) on the waiver (waiver cost plus other Medicaid services), cannot exceed the total aggregate cost to Medicaid for serving the recipient (s) in an appropriate institutional setting(s).

Current Indiana Waivers include:

- Aged and Disabled Waiver
- Autism Waiver
- DD Waiver
- Medically Fragile Children's Waiver
- Traumatic Brain Injury Waiver
- Assisted Living Waiver
- Support Services Waiver

Work One

Work One Centers are places that assist customers in finding workers or finding jobs. Partnering agencies are able to share information about customers that gives the Center a "single agency" appearance (although customers that want to work with a single agency can restrict information to that agency.)

SECTION VI: OTHER RESOURCES

The Indiana Governor's Planning Council
http://www.in.gov/gpcpd/

Administration on Aging, Department of Health and Human Services
http://www.aoa.dhhs.gov/

National Information Center for
Children and Youth with Disabilities
http://nichcy.org/index.html#about

State Agencies and Organizations

United States Senators
Honorable Richard G. Lugar (R)
United States Senate
306 Hart Senate Office Building
Washington, DC 20510-1401
(202) 224-4814
E-mail: senator_lugar@lugar.senate.gov
Web: www.senate.gov/~lugar/

Honorable Evan Bayh (D)
United States Senate
717 Hart Building
Washington, DC 20510
(202) 224-5623
(202) 228-1377 (fax)
Web: www.senate.gov/~bayh/

Governor
Honorable Frank O'Bannon
State House, Room 206
Indianapolis, IN 46204
(317) 232-4567
E-mail: fobannon@state.in.us
Web: www.ai.org/gov/index.html

State Department of Education: Special Education
Robert Marra, Associate Superintendent
Indiana Department of Education
State House, Room 229
Indianapolis, IN 46204-2798
(317) 232-0570
E-mail: rmarra@doe.state.in.us
Web: http://web.indstate.edu/soe/iseas/dse.html

Programs for Infants and Toddlers with Disabilities: Ages Birth through 2
J. Lanier DeGrella, Assistant Deputy Director
Indiana Family and Social Services Administration
Division of Family Resources
Bureau of Child Development
402 W. Washington Street, Room W-386
Indianapolis, IN 46204
(317) 233-9229

E-mail: jdegrella@fssa.state.in.us
Web: www.in.gov/fssa/first_step/

Programs for Children with Disabilities: Ages 3 through 5
Sheron Cochran, Preschool Coordinator
Division of Exceptional Learners
Indiana Department of Education
State House, Room 229
Indianapolis, IN 46204-2798
(317) 232-0567
E-mail: scochran@doe.state.in.us
Web: http://web.indstate.edu/soe/iseas/dse.html

State Vocational Rehabilitation Agency
Nancy Zemaitis, Interim Deputy Director
Vocational Rehabilitation Services
Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
402 W. Washington Street, Room W453
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-1319; (800) 545-7763, ext. 1319
E-mail: nzemaitis@fssa.state.in.us
Web: www.IN.gov/fssa/

Office of State Coordinator of Vocational Education for Students with Disabilities
Terry Fields, State Director
Vocational and Technical Education
Indiana Workforce Development
10 N. Senate Avenue, Room 212
Indianapolis, IN 46204-2277
(317) 232-1829
E-mail: tfields@dwd.state.in.us
Web: www.IN.gov/dwd/teched/

State Mental Health Agency
Janet Corson, Director
Division of Mental Health and Addiction
Family and Social Services Administration
402 W. Washington Street, Room W353
Indianapolis, IN 46204-2739
(317) 232-7845
E-mail: jcorson@fssa.state.in.us
Web: www.IN.gov/fssa

State Mental Health Representative for Children
Children's Services Bureau
Division of Mental Health and Addiction
Family and Social Services Administration
402 W. Washington Street, Room W353
Indianapolis, IN 46204-2739
(317) 232-7934
Web: www.IN.gov/fssa

State Developmental Disabilities Agency
Steven C. Cook, Director
Bureau of Developmental Disabilities

Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7842

State Developmental Disabilities Planning Council
Suellen Jackson-Boner, Director
Governor's Planning Council for People with Disabilities
150 W. Market Street, Suite 628
Indianapolis, IN 46204
(317) 232-7770; (317) 232-7771 (TTY)
E-mail: gpcpd@gpcpd.org
Web: www.IN.gov/gpcpd

Protection and Advocacy Agency
Thomas Gallagher, Executive Director
Indiana Protection and Advocacy Services
4701 N. Keystone Avenue, Suite 222
Indianapolis, IN 46205
(317) 722-5555
(800) 622-4845; (800) 838-1131 (TTY)
E-mail: info@ipas.state.in.us
Web: www.IN.gov/ipas

Client Assistance Program
Contact Protection and Advocacy Agency listed above

Programs for Children with Special Health Care Needs
Children's Special Health Care Services
Indiana State Department of Health
2 N. Meridian Street, Section 7-B
Indianapolis, IN 46204
(317) 233-5578

State Agency for the Blind and Visually Impaired
Linda Quarles, Interim Deputy Director
Blind and Visually Impaired Services
Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
402 W. Washington Street, Room W-453
P. O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-1433; (877) 241-8144
(317) 232-1466 (TTY)
E-mail: lquarles@fssa.state.in.us
Web: www.state.in.us/fssa/servicedisabl/blind/index.html

Programs for Children and Youth who are Deaf or Hard of Hearing
James Van Manen, Deputy Director
Deaf and Hard of Hearing Services
Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
402 W. Washington Street , Room W-453
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-1143 (V/TTY); (800) 962-8408 (V/TTY in IN only)

E-mail: jvanmanen@fssa.state.in.us
Web: www.IN.gov/fssa/dhhs

Regional ADA Technical Assistance Agency
Robin Jones, Project Director
Great Lakes Disability and Business Technical Assistance Center
University of Illinois/Chicago
Department on Disability and Human Development
1640 W. Roosevelt Road
Chicago, IL 60608
(312) 413-1407 (V/TTY); (800) 949-4232 (V/TTY)
E-mail: gldbtac@uic.edu
Web: www.adagreatlakes.org

University Centers for Excellence on Developmental Disabilities
(formerly University Affiliated Programs)
David M. Mank, Director
Indiana Institute on Disability and Community
2853 E. Tenth Street
Bloomington, IN 47408-2696
(812) 855-6508; (812) 855-9396 (TTY)
E-mail: uap@indiana.edu
Web: www.iidc.indiana.edu

John D. Rau, M.D., Director
Riley Child Development Center (RCDC)
Leadership Education in Neurodevelopmental Disabilities (LEND) Program
Indiana University School of Medicine
James Whitcomb Riley Hospital for Children
702 Barnhill Drive, Room 5837
Indianapolis, IN 46202-5225
(317) 274-8167
E-mail: jdrau@child-dev.com
Web: www.child-dev.com

Technology-Related Assistance
Cris Fulford, Executive Director
ATTAIN, Inc.
2346 S. Lynhurst Drive, Suite 507
Indianapolis, IN 46241
(317) 486-8808; (800) 528-8246 (in IN)
E-mail: attain@attaininc.org
Web: www.attaininc.org

State Mediation System
Sally Cook, Coordinator
Indiana Department of Education
Division of Exceptional Learners
State House, Room 229
Indianapolis, IN 46204
(317) 232-0580
E-mail: sacook@doe.state.in.us
Web: web.indstate.edu/soe/iseas/dse.html

Disability-Specific Organizations

Attention Deficit Disorder
To identify an ADD group in your state or locality, contact either:

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 201
Landover, MD 20785
(301) 306-7070
(800) 233-4050 (Voice mail to request information packet)
E-mail: national@chadd.org
Web: www.chadd.org
National Attention Deficit Disorder Association (ADDA)
1788 Second Street, Suite 200
Highland Park, IL 60035
(847) 432-2332
E-mail: mail@add.org
Web: www.add.org

Autism

Cathy Pratt, Ph.D., Director
Indiana Resource Center for Autism (IRCA)
Indiana Institute on Disability and Community
2853 E. Tenth Street
Bloomington, IN 47408-2696
(812) 855-6508; (812) 855-9396 (TTY)
E-mail: prattc@Indiana.edu
Web: www.iidc.indiana.edu/

Brain Injury

John P. Young, Chairman, Board of Directors
Brain Injury Association of Indiana
1525 N. Ritter Avenue, Mikolon Building
Indianapolis, IN 46219
(317) 356-7722; (866) 854-4246
E-mail: BIAI@iquest.net
Web: www.biausa.org/indiana/bia.htm

Cerebral Palsy

Donna Roberts, Executive Director
United Cerebral Palsy Association of Greater Indiana, Inc.
615 N. Alabama Street, Room 322
Indianapolis, IN 46204
(317) 632-3561; (800) 723-7620
E-mail: ucpaindy@ucpaindy.org

Down Syndrome

Indiana Down Syndrome Foundation
233 McCrea Street, Suite 200
Indianapolis, IN 46225
(317) 216-6319; (888) 989-9255
E-mail: dsani@aol.com
Web: www.indianadsf.org

Deb Gavette, President
Down Syndrome Association of Northeast Indiana
P.O. Box 50305
Fort Wayne, IN 46815
(260) 471-9964; (877) 713-7264
E-mail: dsani4u@aol.com

Web: www.dsani.org

Epilepsy

Marge Frommeyer, Executive Director
Epilepsy Council of Greater Cincinnati, Inc.
(serving Clark, Floyd and South Eastern Counties)
3 Centennial Plaza, 895 Central Avenue
Cincinnati, OH 45202
(513) 721-2905
E-mail: ecgc@fuse.net
Web: www.ecgc.net

Learning Disabilities

Dawn Lytle, Indiana State President
Learning Disabilities Association of Indiana
P.O. Box 20584
Indianapolis, IN 46220
(800) 284-2519 (LD and ADD/HD Information Request Line)
E-mail: dlytle@kokomo.k12.in.us
Web: www.ldaamerica.org

Mental Health

Stephen McCaffrey, President
Mental Health Association in Indiana, Inc.
55 Monument Circle, Suite 455
Indianapolis, IN 46204
(317) 638-3501; (800) 555-6424 (in IN only)
E-mail: mha@mentalhealthassociation.com
Web: www.mentalhealthassociation.com

Pamela A. McConey, Executive Director
NAMI Indiana (National Alliance for the Mentally Ill, IN)
P.O. Box 22697
Indianapolis, IN 46222-0697
(317) 925-9399; (800) 677-6442
E-mail: nami-in@nami.org
Web: www.namiindiana.org

Mental Retardation

John Dickerson, Executive Director
The Arc of Indiana
22 E. Washington Street, Suite 210
Indianapolis, IN 46204
(317) 977-2375
E-mail: jdickerson@iquest.net
Web: www.arcind.org
Web: www.TheArcLink.org

Speech and Hearing

Michael Flahive, President
Indiana Speech-Language-Hearing Association
233 McCrea Street, Suite 200
Indianapolis, IN 46225
(317) 955-1063
E-mail: isha@in-motion.net

Web: www.islha.org

Spina Bifida

Spina Bifida Association of Northern Indiana
2421-01 Nappanee Street
Elkhart, IN 46517
(574) 295-3988; (866) 822-6499

Kim Zink, Coordinator
Wabash Valley Spina Bifida Support Group
P.O. Box 21
Farmersburg, IN 47850
(812) 696-2288
E-mail: spinabifida@earthlink.net
Web: www.homestead.com/planetzachary/main.html

Visual Impairments

Jay Stiteley, Director
American Foundation for the Blind-Midwest
401 N. Michigan Avenue, Suite 350
Chicago, IL 60611
(312) 396-4420
E-mail: chicago@afb.net
Web: www.afb.org

Organizations Especially for Parents

Parent Training and Information Center (PTI)
Richard Burden, Executive Director
IN*SOURCE
809 N. Michigan Street
South Bend, IN 46601-1036
(219) 234-7101 (V/TTY); (219) 239-7575 (TTY)
(800) 332-4433 (In IN)
E-mail: insource@insource.org
Web: www.insource.org

Parent-To-Parent
Donna Gore Olsen, Executive Director
Indiana Parent Information Network, Inc.
4755 Kingsway Drive, Suite 105-A
Indianapolis, IN 46205-1545
(317) 257-8683
E-mail: FamilyNetw@aol.com
Web: www.ai.org/ipin

Parent Teacher Association (PTA)
Mary Williams, President
Indiana Congress of Parents and Teachers, Inc.
2525 N. Shadeland Avenue, D-4
Indianapolis, IN 46219
(317) 357-5881
E-mail: in_office@pta.org
E-mail: pta@spitfire.net
Web: www.indianapta.org

Other Disability Organizations

Pat Bowers, Executive Director
Easter Seals Wayne/Union Counties
5632 U.S. Highway 40 East
P.O. Box 86
Centerville, IN 47330-0086
(765) 855-2482
E-mail: easterseals@juno.com

Jim Nulty, President
VSA Arts of Indiana
Harrison Centre for the Arts
1505 N. Delaware Avenue
Indianapolis, IN 46202
(317) 974-4123; (317) 974-4117 (TTY)
E-mail: jnulty@vsai.org
Web: www.vsai.org

BIBLIOGRAPHY

[i] US Census Bureau, 2000
[ii] Administration on Aging, Summary Table of Age Characteristics of the older Population for the Unites and for States: 2000
[iii] Indiana *Quick*Facts, US Census Bureau, www.quickfacts.census.gov
[iv] Administration on Aging, “A profile of Older Americans: 2001”
[v] "FSSA: A Report on Families," October 2002.
[vi] "FSSA: A Report on Families," October 2002
[vii] DMHA bureau booklet 2003
[viii] www.nami.org
[ix] "Mental Health: A Report of the US Surgeon General," 1999.
[x] www.in.gov/fssa/servicemental/pub/misafinal.pdf
[xi] Nancy N. Eustis Ph.D., Robert F. Clark D.P.A, Michele C. Adler M.P.H., “Disability Data for Disability Policy: Availability, Access and Analysis”, August 1995.
[xii] US Census Bureau, "Profile of General Demographic Characteristics: 2000"
[xiii] "FSSA: A Report on Families," October 2002.
[xiv] O'Hare, William and Megan Reynolds, "High Risk Kids in America during the 1990s," Baltimore: Annie E. Casey Foundation, 2001.
[xv] Commission on Affordable Housing Minority report
[xvi] "FSSA: A Report on Families," October 2002
[xvii] od.org
[xviii] National Organization on Disability. www.nod.org.. May 15, 2002.
[xix] www.nod.org
[xx] US Census Bureau, 2000
[xxi] Statewide In-Home Services, "2000 Annual Report".
[xxii] U.S. Census Bureau, State and County QuickFacts, Indiana, 2002.
[xxiii] FSSA, Demographic Trend Report, State Fiscal Year 2001.
[xxiv] FSSA, Demographic Trend Report, State Fiscal Year 2001.
[xxv] Brian Jones, INDOT
[xxvi] FSSA 2002-2003 Budget Presentation, “Helping People Help Themselves”.
[xxvii] Division of Mental Health and Addiction, "Biennial Report: SFY 2000 - 2001," p. 15.
[xxviii] Ibid.
[xxix] FSSA Budget Office, October 2002.
[xxx] Administration on Aging, FY 2000 Profile of State OAA Programs: Indiana
[xxxi] Office of Medicaid Policy and Planing 2002; Data Analysis 2002

G. Best Practices

Governor's Commission on Home and Community-Based Services

Best Practices

March 27, 2003

integrity respect service creativity

Overview

- There have been many successful Home and Community-Based initiatives in other states.
- This presentation is intended to summarize some of those initiatives that might be of interest to the Governor's Commission on Home and Community-Based Services.
- This presentation is not meant to be an exhaustive description of all programs. Rather, it should serve as a beginning point to this discussion.

Promising Practices in Home and Community Based Services

- The Centers for Medicare and Medicaid Services (CMS) has created a website (*www.com.gov/promisingpractices*) of Promising Practices reports on Home and Community-Based Services. Most reports are being developed by The MEDSTAT Group under contract with the Disabled and Elderly Health Programs Group within CMS.
- Some states are undertaking comprehensive reform of their entire system of home and community-based services. Others are identifying specific components as targets for incremental improvement. Thus, while some reports focus on "whole systems," most focus on discrete components that can be incorporated into an overall program design.

Topics

1. Coherent, Cost-Effective Administration and Financing
   - One-Stop Shopping and Person-Centered Service Delivery Systems
   - Assisting Individuals to Avoid or Move from Institutional Settings
2. Promoting Independence, Responsibility, and Participant-Driven Services
3. Assistance to Families and Community Caregivers
4. Access, Case Management, and Coordination
5. Accountability, Quality, and Fulfillment of Legal Obligations
6. Other Critical Supports for Community Inclusion and Participation

Coherent, Cost-Effective Administration and Financing

- Goals of these reform efforts might include:
  - Creating flexible long-term support payment mechanisms that follow individuals to their most appropriate and desired settings
  - Reducing institutional biases in Medicare and Medicaid
  - Developing individual program participation rules that eliminate eligibility cliffs and ensure equal treatment of similarly situated groups
- Also included in this category are promising practices that facilitate the active participation of older persons, people with disabilities, and other stakeholders in the design and administration of community long-term support systems.

Coherent, Cost-Effective Administration and Financing

- **Michigan:** Person-Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities
  - Michigan contracts with its Community Mental Health Services Programs as a health plan for services. To ensure access and improve choice, the contracts require local agencies to offer a wide array of services and use a person-centered planning process to determine a person's service plan.
- **California:** Comprehensive, Individualized Services for People with Serious Mental Illnesses Through a Single Provider
  - Village Integrated Service Agency provides coordinated, comprehensive services for people with mental illness.
- **New York:** Managed Long-Term Care Plan (MLTC) for Integrated Long-Term Care Services
  - The Visiting Nurse Service established a long-term care program for older people with disabilities (VNS CHOICE) as a part of New York's partially capitated MLTC program. The program has reduced hospital and nursing home use among participants and has low disenrollment.

One Stop Shopping and Person Centered Service Delivery Systems

- **Pennsylvania:** Transformation of Supports for People With Mental Retardation
  - Program emphasizes single entry points and person-centered services. Participants are offered a greater choice of supports, providers, and methods of service delivery, as well as better coordination with federal HCBS waivers.
- **Wisconsin:** Family Care
  - Aging and Disability Resource Centers provide a clearly identifiable single entry point for information, advice, and access to a wide range of community resources for older people and people with disabilities. Care Management Organizations (CMO) manage the Family Care benefit, consolidating funding from multiple program authorities into a single capitation payment to the CMO.

Assisting Individuals to Avoid or Move from Institutional Settings

- Many states have engaged in activities and developed programs that serve persons in the most appropriate community setting rather than in an institution.
- These programs and activities have included:
  - diversion programs to maintain people in the community
  - transition programs to actively move individuals from institutional settings to alternative community placements
  - program models in which the "money follows the person" to assure stability of community living

Assisting Individuals to Avoid or Move from Institutional Settings

- **Utah:** Informing Nursing Home Residents about Community Long-Term Care Options
  - Nursing home resident education project with the local Independent Living Centers and local Area Agencies on Aging about other long-term care options.
- **Colorado:** Community Options for People Discharged from Hospitals
  - The Fast Track program coordinates Medicaid HCBS waiver case managers and Medicaid financial eligibility staff at a major urban hospital to facilitate quick eligibility determination for hospital patients who need long-term care after discharge. Between March 1999 and June 2001, 149 people avoided likely nursing facility residency and successfully started receiving HCBS after a hospital discharge.

Assisting Individuals to Avoid or Move from Institutional Settings

- **Florida:** Providing Managed Care Organizations with Financial Incentives to Expand Community Care and Nursing Home Care
  - A managed long-term care pilot project encourages coordination of acute and long-term care services for people age 65 or older with disabilities. Participating HMOs must absorb the costs of lifetime nursing home care, if it is required for individuals enrolled in the pilot.
- ★ **New Jersey:** Information and Assistance to People in Nursing Facilities
  - Community Choice is one of the few permanent, state-operated nursing facility transition programs. Forty counselors provide information and assistance to nursing facility residents throughout the state. New Jersey established a fund for transition expenses for which no other funding source is available, such as furniture and housing deposits. Community Choice helped more than 3,400 people leave nursing facilities during state fiscal years 1998 through 2001.

Assisting Individuals to Avoid or Move from Institutional Settings

- **Texas:** Rider 37: Promoting Independence "Money Follows the Person"
  - With the passing of Rider 37, Medicaid funding may now follow an individual who moves from a nursing facility into the community. Since the Rider became effective in September 2001, over 950 Medicaid participants in Texas have transitioned from nursing facilities into their community, using their nursing facility funding.
- **Vermont:** Facilitating Nursing Facility to Community Transitions
  - The following efforts were made: a change in the waiting list policy for Vermont's largest Medicaid HCBS waiver for older people and people with physical disabilities, a statewide system of local Long-Term Care Community Coalitions to improve HCBS infrastructure, and a new Medicaid HCBS waiver for community residential options. These efforts resulted in a drop of Vermont's long-term care expenditures from 88 to 63% between 1996 and 2002.

Assisting Individuals to Avoid or Move from Institutional Settings

- ★ **Washington:** Facilitating Nursing Facility to Community Transitions
  - Nursing facility case managers help people obtain the housing and services necessary to leave a nursing facility. Washington also uses Medicaid post-eligibility treatment of income rules to allow Medicaid-eligible residents to keep more of their income to maintain their home or obtain and furnish a home after transition. The state also offers four funding sources for transitional services people may need when leaving a nursing facility. Over a five-year period, the number of nursing facility residents using Medicaid decreased 16%
- **Wisconsin:** Assistance to People Who Want To Leave Nursing Facilities
  - In 2001, 150 people were helped to leave nursing facilities who wanted to move into the community by targeting resources. The state set aside state and Medicaid HCBS waiver funds to pay for one-time transition expenses and for ongoing home and community-based services.

Promoting Independence, Responsibility, and Participant-Driven Services

- In some states, new design initiatives are being undertaken to make people the focus of funding and service planning, rather than each individual service and provider class.
- In some instances, attention is being focused on developing entirely new program infrastructures that support consumer-directed services, including:
  - Developing flexible home and community-based service funding
  - Assisting consumers in purchasing services through support brokerage and similar methods
  - Expanding the supply of accessible housing
  - Creating emergency back-up systems for personal assistance or other services
  - Assigning consumers the responsibility for developing their own service and budget plan

Promoting Independence, Responsibility, and Participant-Driven Services

- ★ **Arkansas:** Independent Choices - The Arkansas Cash and Counseling Demonstration
  - Demonstration project measures the impact of substituting a cash allowance for Medicaid services from provider agencies. People with disabilities are randomly assigned to two groups. The control group receives Medicaid personal care through a provider agency and the treatment group receives a monthly cash allowance and services to help them effectively use the allowance. Early data indicates treatment group participants have less nursing home utilization than control group participants.
- **Florida:** Cash Allowances and Support Services for People with Disabilities
  - Florida is the only state in this demonstration to serve both children and adults with disabilities.

Promoting Independence, Responsibility, and Participant-Driven Services

★ **New Jersey:** Personal Preference: The New Jersey Cash and Counseling Demonstration

- A preliminary study reported 86% of participants would recommend the cash allowance to others.

➢ **Alaska:** Program Changes Based on System's Principles

- Consumer directed personal care agencies train participants to direct their own services and perform fiscal responsibilities for people who employ their own personal assistants. Within the first four months, the program increased the number of participants hiring their own provider by 36%.

Promoting Independence, Responsibility, and Participant-Driven Services

★ **Oregon:** Maximizing Participant Control Over Services

- Independent Choices Program allows Medicaid-eligible individuals to pay cash directly to providers for personal care and related services. Under this five-year project, consumers receive a monthly cash amount and are fully responsible for the mechanics of payroll and budgeting for needed services. An independent evaluation of the pilot will examine, among other things, whether consumer satisfaction and sense of control have increased in comparison to traditional approaches.

➢ **Colorado:** Increasing Persons' Control Over Personal Attendants

- Participants in the Research and Demonstration Program, which began in 2002, can use money that otherwise would have been spent on Medicaid home health agency and personal care services to purchase in-home services from attendants they personally select, hire, and train.

Promoting Independence, Responsibility, and Participant-Driven Services

- **Michigan:** Person Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities
  - The State of Michigan combined several funding sources in its contracts with local community mental health agencies, which serve people with developmental disabilities, mental illness, and addiction disorders. To ensure access and improve choice, the contracts require local agencies to offer a wide array of services and use a person-centered planning process to determine a person's service plan.
- **Wyoming:** Individual Budgets for Medicaid Waiver Services
  - Individual budgets for HCBS waivers for people with developmental disabilities to improve equity among waiver participants and increase the authority of the consumer's service planning team. The state uses a statistical analysis of state historical data on individuals' needs and services to determine individual consumers' budgets.

Assistance to Families and Community Caregivers

- Most persons in need of long-term support receive their primary assistance with daily activities from their families, not from a paid service provider. Yet, until recently, public policies have not acknowledged or supported families in this important role.
- Public support for caregivers will include ways of equipping them with the information and skills needed to perform their role. These may include:
  - Providing consultation, peer support, and emergency help to deal with the psychological stress of caregiving
  - Help with transportation or/and respite services that will enable them to have temporary relief from the demands of their ongoing role

Assistance to Families and Community Caregivers

- **Massachusetts:** Facilitating Culturally Competent Self-Determination
  - Developed local, ethnic community governing boards to manage service delivery as a part of a self-determination initiative for people with developmental disabilities, taking advantage of relationships and cultural linkages to improve services for people with developmental disabilities in their own communities.
- **North Dakota:** Supporting Family Caregivers with Payment for Services Resource
  - State funds used to provide monthly payments to spouses and other relatives to care for low-income people with disabilities, including older people living at home.

Assistance to Families and Community Caregivers

- **Pennsylvania:** Counseling and Financial Assistance for Informal Caregivers
  - Family Caregiver Support Program uses funds to allow the caregiver to choose the services most needed to help care for an older relative at home and provide financial assistance with out-of-pocket expenses.
- **Utah:** Family-Directed Support Network for Families of People with Disabilities
  - The Family Council is an opportunity for families of individuals with disabilities to provide support, education, and resource information to one another. The Council is a state-wide family-directed support network available to all families of individuals with disabilities, including families who do not receive publicly funded services.

Assistance to Families and Community Caregivers

- **Washington:** Supporting Caregivers in Ethnically Diverse Communities
  - Working with local community organizations, the state used a combination of targeted outreach, community education, case manager advocates, and culturally sensitive diagnostic assessment proceeds to significantly expand caregiver supports for diverse populations.
- **Georgia:** Vouchers Caregivers Use to Pay for Services
  - Legacy Express provides vouchers to caregivers which may be spent on service options ranging from respite and medications to haircuts and lawn care. The objective is to give caregivers the authority and flexibility to select those service options that work best for them. Originally targeted at persons with Alzheimer's disease, the program has gradually been expanded to serve older people.

Access, Case Management, and Coordination

- "One-stop shopping" for coordinated information about a wide range of community long-term supports, as well as to help persons access economic assistance, housing, nutrition, and other public and private sources of support is being developed by some states.
- Other states have made improvements in the efficiency of program enrollment procedures. When consumers seek services from multiple programs, they often encounter duplicative paperwork, repeated requests for the same information, and a lack of attention paid to their specific expectations and preferences. Promising practices are streamlining these enrollment procedures and enhancing consumer-responsive problem solving on the part of service managers.

Access, Case Management, and Coordination

- **Illinois:** Simplified Access for HCBS Waiver and Older Americans Act Services
  - Local Case Coordination Units (CCUs) coordinate eligibility determination and case management for Medicaid waiver services, state-funded home and community-based services, and Older American Act services.
- ★ **New Jersey:** Single Access Point for Information on All Services for Older People
  - Established a single entry system for long-term supports and other services for older people, including a toll free number for information and services. The system is designed to prevent frustration of having to contact multiple offices in order to obtain information and services. The effectiveness of the system in each of New Jersey's 21 counties is evaluated through compliance with state protocols and consumer satisfaction scores.

Access, Case Management, and Coordination

- **Wisconsin:** One-Stop Shopping for Information and Service Access
  - Improved information, advice, and program enrollment for long-term supports for the aged and disabled through the Aging and Disability Resource Centers to the general public. The centers also give in-depth advice about long-term support options and provide a single entry point for persons seeking access to the state's home and community-based services programs, as well as to publicly financed care in nursing facilities, residential settings, and adult family homes.
- **Colorado:** Simplified Access to Nursing Home Alternatives
  - Established Single Entry Point Agencies (SEPs) that provide an access point for several publicly funded long-term supports for people with disabilities, including older people, people with physical disabilities, people living with AIDs, and people with brain injuries. Since SEPs have served the state, participation in community-based services have more than doubled while the number of nursing home residents has been stable.

Accountability, Quality, and Fulfillment of Legal Obligations

- Promising practices will also address ways to ensure that public programs are accountable for the quality of long-term supports provided to persons with disabilities. However, quality concerns are not limited to direct supports, but more broadly relate to the way persons are treated in all of their encounters with community long-term support systems.
- Promising practices in quality assurance and quality improvement will address ways that:
  - Quality is built into every component of a state's home and community-based services system
  - Frequent and accurate customer feedback and other information from the points of service delivery are used effectively to correct or prevent problems
  - Quality problems are systematically identified and remedied
  - The capacity to improve quality is built into the service delivery system

Accountability, Quality, and Fulfillment of Legal Obligations

- ★ **Minnesota:** Quality Measurement Involving Volunteer Reviewers
  - A quality assurance review process for services for people with developmental disabilities is replacing the state's licensing system on a trial basis. Volunteer reviewers evaluate all services for a person, working with the person and the individuals who provide the support, and identify exceptional practices and necessary improvements.
- **Ohio:** Increasing Timely Access to Services
  - Electronic communication between case managers and providers to streamline identification of service providers for program participants.
- **South Carolina:** Improving Responsiveness of Service Managers to Persons' Needs
  - Automated Case Management System (CMS) reminds case managers of needs identified in the assessment that may potentially be included in the service plan.

Other Critical Supports for Community Inclusion and Participation

- As the demand for community-based supports has increased, limitations in the amount, type, and scope of available supports have become more apparent. Promising practices include:
  - Expanding the supply of commonly provided services and developing new types of supports such as accessible housing or home modifications that have not been previously available.
  - Addressing how public programs can support persons of any age and disability to live and participate in the social and economic fabric of neighborhoods, businesses, and family life; particularly in regards to facilitating employment of persons with disabilities and enhancing the availability of transportation and personal assistance services.
  - Supporting individuals who are transitioning from institutional settings to the community and vise versa. Better linkages are being established to broaden community access to primary care physicians and specialty care for older people and people with disabilities.

Other Critical Supports for Community Inclusion and Participation

- **Iowa:** Training, Mentoring, and Increasing Awareness of Direct Support Professionals
  - Created the Certified Nursing Assistants (CNAs) Recruitment and Retention Project. This project focused on professionals in nursing facilities, but may be adapted to support home and community-based service providers. The project established training and mentoring for CNAs and increased awareness of their work.
- **Massachusetts:** Recruiting Direct Service Professionals in a Competitive Environment
  - The Massachusetts Department of Mental Retardation (DMR) and independent provider agencies joined forces to recruit direct support professionals for people with developmental disabilities. DMR and the program in the metro region identified 2,000 potential workers in its first 18 months of operation. Agencies hired more than 200 of these people.

Other Critical Supports for Community Inclusion and Participation

- **Several States:** Recruiting and Hiring Process to Identify Suitable Direct Support Workers
  - The Cooperative Healthcare Network (CHN), a national group of affiliated long-term care providers and training organizations, uses a standardized recruitment approach to attract and retain high quality service professionals through a targeted outreach and rigorous application process. Organized and supported by Paraprofessional Healthcare Institute (PHI), CHN employs over 900 direct care workers in home and community-based settings.
- **Virginia:** Improving Recruitment and Retention of Direct Support Workers
  - The Nursing Assistant Institute (NAI) programs improve the training and support that nursing assistants receive in order to increase recruitment, decrease turnover, and ultimately provide consumers with a stable workforce that is familiar with their healthcare needs.

Best Practices Highlighted

- **Transitions**
  - ★ New Jersey
  - ★ Washington
- **Money Follows the Person**
  - ★ Arkansas
  - ★ New Jersey
- **Consumer Directed Care**
  - ★ Oregon
- **Single Access Point**
  - ★ New Jersey
- **Quality**
  - ★ Minnesota

Additional Questions?

www.com.gov/promisingpractices

egalvin@healthevolutions.com

H. Federal Barriers

Overview of Significant Federal Barriers to Advancing the Long Term Care Delivery System

Introduction

This paper is intended to provide a brief overview of significant Federal barriers that hinder or otherwise limit improvement in further developing the long-term care service delivery system and achieving full compliance with *Olmstead*. Many of the barriers were identified through President George W. Bush's New Freedom Initiative and already are supported by recommendations for improvement or full resolution by the federal agencies responsible for program implementation, operation and compliance. This list of barriers includes some of the more significant but is not intended to be comprehensive.

The barriers that exist under state law or regulation or are caused by system or process inefficiencies are not included in this overview.

In order to better understand the Federal barriers that have been identified, four primary Federal laws have been highlighted for reference below. These include: the Americans with Disabilities Act (ADA); the Civil Rights of Institutionalized Act (CRIPA); the Fair Housing Act; and the Social Security Act (SSA).

The Americans with Disabilities Act or ***ADA*** (42 U.S.C. 12101) broadly protects the rights of individuals with disabilities. The Civil Rights Division's Disability Rights Section is responsible for implementation of regulations and enforcement of Titles II and III of the ADA and for litigation of employment claims under Title I involving state governments. Title II applies to state and local government entities, and, in subtitle A, protects qualified individuals with disabilities from discrimination on the basis of disability in services, programs, and activities. Title III covers, among others, private businesses known as places of public accommodation, including among others, the offices of health care providers, child care centers, and a variety of community-based service providers. The Disability Rights Section is also responsible for coordination of Federal agencies' implementation of ***Section 504 of the Rehabilitation Act of 1973*** as amended (29 U.S.C. 794), which prohibits discrimination on the basis of disability in federally funded and federally conducted programs.[1]

The Civil Rights of Institutionalized Persons Act or ***CRIPA*** (42 U.S.C. 1997) concerns the rights of individuals who reside in institutions operated by or on behalf of a government. CRIPA authorizes the Department to initiate a civil action where there is reasonable cause to believe that a state or political subdivision of a state is engaged in a pattern or practice of subjecting institutionalized individuals to conditions that deprive them of the rights secured by the United States Constitution or Federal laws. The Civil Rights Division's Special Litigation Section enforces CRIPA and handles the majority of the Department's work under Olmstead. In its investigations of health care institutions, the Department collects evidence to determine whether there are violations of Federal statutes and regulations, including the ADA, Section 504 of the Rehabilitation Act, Title XIX of the Social Security Act, and various Medicaid programs.[2]

The Fair Housing Act or ***FHA*** (42 U.S.C. 3601) prohibits discrimination on the basis of disability in all types of housing transactions. The Civil Rights Division's Housing and Civil Enforcement Section shares responsibility for enforcing the FHA with the U.S. Department of Housing and Urban Development (HUD). Under the FHA's accessibility requirements, newly-constructed, multi-family housing must be accessible to and adaptable for use by individuals with disabilities. The FHA's accessibility requirements are more modest than those of the ADA, most notably with respect to spaces inside individual units where the FHA typically requires only that a space can be made usable by individuals with disabilities, including persons who use wheelchairs. The Department also works to ensure that zoning and other regulations concerning land-use are not employed to hinder the residential choices of individuals with disabilities; such hindrances include unnecessarily restricting communal or congregate-residential arrangements, such as group homes. These sorts of residential arrangements are frequently used for community placement of individuals with disabilities.[3]

The Social Security Act, or ***SSA***, and related laws establish a number of programs that: provide for the material needs of individuals and families; protect aged and disabled persons against the expenses of illnesses that may otherwise use up their savings; keep families together; and give children the chance to grow up healthy and secure.[4] The Act includes the following programs:

- Retirement insurance
- Survivors insurance
- Disability insurance
- Hospital and medical insurance for the aged, disabled, and those with end-stage renal disease
- Black lung benefits
- Supplemental Security Income
- Unemployment insurance; and
- Public assistance and welfare services, including:
  - Aid to needy families with children
  - Medical assistance (Medicaid)
  - Maternal and child health services
  - Child support enforcement
  - Family and child welfare services
  - Food stamps; and
  - Energy Assistance

The Ticket to Work and Work Incentives Improvement Act (TWIIA) of 1999 was enacted to allow individuals with disabilities to work. Title I of the Act provides access to employment training and placement services and Title II of the Act provides health care supports for working individuals with disabilities. Additionally, Title II establishes two optional Medicaid eligibility categories, extends the period of premium free Medicare Part A eligibility, and requires consumer protection for certain individuals with

Medigap coverage. These health care provisions are administered by the U.S. Department of Health and Human Services.

The Workforce Investment Act of 1998 (WIA) provides the framework for delivery of employment and training services at the state and local levels to both employers and job seekers, including dislocated workers, new entrants to the workforce, and people with disabilities. It creates "One Stop Centers" that are intended to make a comprehensive range of employment, training, and related services available in a local community. WIA also identifies multiple programs and agencies that are to be workforce system partners, both required and optional, which must coordinate their programs and services through the local One Stop Center System. State vocational rehabilitation programs are requried partners with local One Stop Centers and provide them with technical assistance.

Federal Barriers to Eligibility and Benefits

1. Institutional Bias

Medicaid

The Medicaid Program, which is a significant source of funding for long-term care provided to people with disabilities and the frail elderly, designates institutional care as an entitlement within the Program. What this means is that Federal law requires states to provide institutional care in order to participate in Medicaid, but does not do the same for care provided in the community, even though community care may be more desirable by consumers and less costly. The institutional bias is furthered by the fact that Medicaid pays for all room and board costs for consumers who receive nursing home, hospital, and intermediate care facility/mentally retarded (ICF/MF) services, while Medicaid funds can not be used to pay for room and board in the community. Therefore, in many cases Medicaid recipients can not afford to remain at home and instead must "choose" institutional care, even though it is more costly.

Further, according to a recent report prepared by the U.S. Department of Health and Human Services (HHS),

> "While Medicaid is a critical program and a significant source of funding for long-term care for people with disabilities, the rules for coverage, eligibility and administration favor spending on institutional care. The public input to HHS' self-evaluation emphasized that these rules result in a "bias" towards institutional care and often result in institutionalization of children, adults and seniors even when community care is less expensive and more appropriate for the individual. Historically, categorical eligibility and coverage rules have impeded state flexibility, frequently leaving consumers without real choice and the opportunity to direct their own care. Medicaid's structure and method of financing also results in differences in the services available to different populations. Of particular concern is the gap in home and community-based services for adults and children with mental illness and emotional disturbance."[5]

Medicare

Certain Medicare rules for home health care and durable medical equipment limit eligibility for benefits by creating very prescriptive requirements for consumers. An example of this is the definition of homebound, which strictly limits a consumer's ability to remain active in the community.

Another example of institutional bias is Medicare copayment policies with respect to mental health treatment.

Medicare coverage consists of two parts: Medicare Part A, which covers hospital-based mental health care, including room, meals, nursing and other related services and supplies; and Medicare Part B, which helps to cover outpatient mental health care, including lab tests and visits with doctors, psychologists, and social workers. Medicare Part B includes a copayment requirement that favors the institutional services: 50%

copayment for outpatient mental health care, compared to a 20% copayment for all other services.

Veterans Benefits

Similarly, the Veterans Health Administration currently has only statutory authority to pay for nursing home care. As a result, many veterans who could reside in a less restrictive environment are placed in nursing homes because they do not have the personal income to pay for assisted living or other forms of board and care.

2. Institutional Care for Mentally Ill Adults Age 21-65

An institution for mental disease, or IMD, is defined as a public or private facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." This includes not just hospitals for individuals with mental illness but also nursing homes or other long-term care facilities that primarily serve such individuals. Federal Medicaid matching funds are not allowable for the costs of any Medicaid covered services furnished to an individual under 65 years of age who resides in an IMD.[6]

While individuals retain their Medicaid eligibility during a stay in an IMD or correctional facility, states often let such eligibility lapse if the institutional stay exceeds six months. The reason for this is that federal matching funds are not available for health care services provided to individuals during their residence in such institutions. Such lapses in eligibility create significant continuity of care problems when the individuals leave the institution for the community. This is particularly true for persons with a mental illness or HIV-AIDS who require a daily regimen of medically-monitored drugs that are critical to their health and daily functioning. States are unclear both about their responsibilities under the law and the current options for ensuring continuity of care.[7]

Similarly, persons who are residents in a public institutional for a full calendar month or longer, generally lose their Supplemental Security Income (SSI) benefits, making a return to the community very difficult financially. And for many, the SSI payments are the primary or only source of income for the individual.

3. Fragmentation of Federal Programs

The Federal government pays for services for people with a serious mental illness primarily through four programs: Medicaid; Medicare; Vocational Rehabilitation; and housing. Service access and delivery problems arise because none of these programs are particularly designed to promote a service delivery system that will produce good mental health care. Health outcomes are difficult to measure, care is largely uncoordinated, and no one is specifically designated to take responsibility for the care that is provided. Further, federal agencies are not typically skillful in promoting, developing and reproducing effective programs in communities.[8]

Moreover Medicaid, as the largest public payer for mental health care, does not reimburse for vocational training and support for individuals with a mental illness, even though many individuals with developmental disabilities receive the same services. Persons with mental illness are often referred to Vocational Rehabilitation, but their employment outcomes are very poor nationwide.[9]

Another example of problems created by the lack of coordination between federal programs is the link between disability payments paid by the Social Security Administration and health care eligibility through Medicaid. Because the Social Security payments are insufficient to cover both the costs of housing and medical, many people with mental illness are prevented from returning work because they will lose their eligibility for Medicaid.

> "The high costs of health care and the unavailability of employer-based health care for people with a "preexisting condition" means that thousands of people with a mental illness make a conscious choice to stay on disability assistance because it provides Medicaid coverage for their expensive medication and treatment needs."[10]

And finally, project-based and voucher housing programs are available to persons with disabilities but are very complicated and have long waiting lists. Even though the programs are subject to HUD guidelines, they may be administered by sub-grantees, have a different point of entry, and maintain their own waiting list.

Perhaps the best description of program fragmentation can be found in a recent report prepared by the U.S. Department of Health and Human Services,

> "Individuals with disabilities face barriers to community living because the right "mix" of services and supports is rarely provided in one package. Instead, individuals with disabilities, their families and caregivers frequently must put together services and supports from multiple service programs, each of which may have its own funding streams, eligibility requirements, policies, procedures, and service sites. The difficulty of negotiating these programs is compounded by lack of accurate information and assistance. Fragmentation and lack of coordination exists at all levels of government – both within individual agencies and across agencies. The lack of an agency focal point within HHS increases the challenge of adequate disability programmatic and policy coordination."[11]

Federal Barriers to Affordable, Accessible Housing

1. Private Housing Providers

HUD's Section 504 regulations treat private housing providers participating in the Section 8 housing voucher program as "contractors" rather than as "recipients" of federal financial assistance. As a result of this designation, these housing providers are not required to meet all requirements for assuring accessibility of their programs, services and activities, thereby further limiting the housing choices available to persons with disabilities. In addition, the entity that administers the voucher program is a recipient and must assure that private landlords participating in the program do not discriminate, must assist applicants in locating accessible units, request exceptions to the Fair Market Rents, and meet other requirements. Persons with disabilities nevertheless are often not aware of the requirements imposed on the recipient and might not know to request this type of assistance.

2. Consumer Education and Outreach

There are no consumer-friendly public documents or counseling programs staffed with persons who are familiar with fair housing laws like Section 504, the ADA and the Fair Housing Act. This is particular detrimental for persons with disabilities who are attempting to move out of institutions into the community. Many of these individuals may not be aware of discrimination or may not fully understand fair housing/Section 504 issues such as reasonable accommodation rights, eligibility for certain HUD programs, and overlapping accessibility requirements of the laws.

3. Homeownership

HUD's Section 504 regulations include a separate section on homeownership (24 CFR 8.29) that focuses on four programs that are no longer active. The regulation also includes requirements for new construction or alterations of any type of housing program. Some offices have, nevertheless, misinterpreted the regulations to require newly constructed or altered homeownership housing programs to comply with the section that covers the four now inactive programs, and not to the provisions in the regulations for new construction and alterations. As a result, some new housing homeownership programs developed under HUD's Hope VI and HOME programs do not meet the accessibility requirements in the regulations, further reducing the accessible housing stock available to persons leaving institutions.

4. Supportive Housing for Persons with Disabilities Program

There is a lack of flexibility within the Section 811 Supportive Housing for Persons with Disabilities Program to develop more integrated housing with less supportive services.

5. Housing Choice Voucher

Current legislation (Section 8 of the United States Housing Act) and HUD regulations (24 CFR Part 982) for the Housing Choice Voucher state that at the time a family initially receives tenant-based assistance, the total rent that the family may be required to pay may not exceed 40 percent of the family's adjusted annual income. This provision could cause families, including those that are disabled, to be unable to rent higher priced units in some communities.

In addition, many persons with disabilities receive only Supplemental Security Income (SSI) payments as income, which amounts to approximately $6,000 per year per person. Therefore, if given a voucher, a person with a disability may not have the personal funds needed to meet the normal expenses involved with moving into an apartment, such as security deposit, utility deposit, money to purchase furniture and other household items and supplies, etc.

And finally, some Public Housing Authorities (PHAs) are not sufficiently familiar with Housing Choice Voucher regulations at 24 CFR 982.303. These regulations allow the PHAs discretion to grant a family "one or more" extensions of the required initial term of at least 60 calendar days to lease an apartment. Moreover, if a disabled family requests an extension as a "reasonable accommodation", then the PHA must extend the voucher term up to the term "reasonably required for that purpose." This flexibility is necessary because it often takes a long period of time for a disabled family to locate an apartment, either because of the limitations of their disability or because of a lack of accessible housing in their communities.

And finally, some PHAs are not requesting an adequate number of vouchers to meet the housing needs of non-elderly disabled families affected by designated housing plans.[12]

6. Data and Reporting

The new version of Form HUD-50058, Family Report, makes improvements in the collection of data on families utilizing the voucher program but does not capture data related to the accessibility of units in privately-owned apartment buildings. Without this information, HUD still will not know to what extent disabled voucher families' needs for accessible units are being met in this program.

The form also does not indicate if the voucher is one that is targeted specifically to a person with a disability. Consequently, there is no way to know if these targeted vouchers specifically issued to a PHA for disabled families have been issued to such families. Further, there is no requirement that a PHA report on the number of "general purpose" vouchers that have been provided to disabled families.

Federal Barriers to Transportation

1. Curb Cuts (Curb Ramps)

Curb cuts are the sloping transitions between sidewalks and streets and roads that make independent movement easier for persons with mobility-related disabilities. Although curb cuts have been required in projects and programs that receive federal financial assistance since 1973, hundreds of thousands have not been built. Additionally, many curb cuts that have been built have not been properly maintained or were not built correctly[13].

Jurisdiction for curb cuts is generally assigned to two federal agencies: the Federal Department of Transportation (DOT) and the Federal Highway Administration (FHWA). The DOT generally has jurisdiction for curb cuts, which are specified in 49 CFR part 27, which implements Section 504 of the Rehabilitation Act (29 U.S.C.794). The FHWA has specific ADA policies for statewide planning in 23 CFR 450.220(a)(4), for metropolitan planning in 23 CFR 450.316(b)(3), and for the National Environmental Policy Act (NEPA) process in 23 CFR 771.105(f).

2. Limitations of the Americans with Disabilities Act (ADA)

The ADA only makes existing transportation accessible; it does not address the many transportation gaps that exist.

Paratransit is the parallel public transit system set up under the ADA to provide complementary, accessible transportation services to people with mobility impairments who live in areas served by fixed route public transit systems. It is enforced by the Federal Transit Authority.

Paratransit is very expensive and heavily subsidized. Problems include: illegal limits placed on quantity of services by transit providers; lack of timely service; and missed calls for pick-ups. Other concerns related to paratransit or fixed route transportation include: the functionality of working equipment; stop announcements; consumer securement; driver training; and scheduling.

Nearly 1,300 rural counties in the U.S. have no public transportation. Accessible rural public transportation systems are rare and costly to operate due to low usage and long distances traveled.[14]

Other programs offered through HUD and HHS do not require transit transfer locations to be provided in their projects, particularly in renovation and new construction. Therefore, the critical link for persons with disabilities between accessible housing, transportation and employment often does not exist because the program initiatives are not coordinated.

Federal Barriers Relating to Compliance

1. Housing Construction and Design

Section 504 of the Rehabilitation Act of 1973 and the Fair Housing Act of 1988 at the design review stage of construction of new public housing include requirements regarding the provision of accessible and adaptable residences for residents with physical disabilities. These requirements are not enforced, so non-compliance is usually discovered after the public housing project is built.

There is also widespread non-compliance with the FHA's new construction requirements for multi-family housing by both private and public providers. Much of this noncompliance can be attributed to a lack of knowledge about the requirements on the part of builders, architects, and engineers. Moreover, the systematic failure to build new housing in compliance with Federal accessibility requirements creates a situation where access is eventually achieved only through modifications or retrofits to existing housing.

While the incorporation of accessible or adaptable features in housing involves little if any cost at the design or the construction stage, retrofitting to bring non-compliant, multi-family housing and public housing into compliance with the FHA and Section 504 can be expensive and difficult. Similarly, many housing providers do not understand the FHA's prohibitions against discrimination on the basis of disability. These prohibitions include the obligation to provide reasonable accommodations for persons with disabilities or to allow such persons to make reasonable structural modifications to dwellings to improve accessibility.[15]

Even newly-constructed, multi-family housing that complies with FHA requirements is often not fully accessible to all persons with mobility disabilities, since the FHA requires only a modest level of accessibility or adaptability for persons who use wheelchairs. Also, the FHA only requires accessibility features in newly constructed multi-family housing with four or more units; therefore, most single-family housing developments built today do not provide any options for accessible single-family homes.

2. Discrimination

Many public housing authorities are not in compliance with the nondiscrimination requirements of the FHA and Section 504 of the Rehabilitation Act regarding access to public and/or Section 8 housing for persons with disabilities.

In communities where accessible housing does exist, some housing providers still have policies that exclude or place discriminatory conditions of residence on persons with disabilities. Examples include assisted living facilities with policies barring residents from using scooters or electric wheelchairs, or retirement communities that deny residence to person with certain types of visible disabilities.

And finally, in many communities across the country, there continues to be strong opposition by citizens and their elected officials to the location of group homes, assisted living facilities, and other facilities for persons with disabilities in residential settings. This community opposition often means that group homes are not built, thereby severely curtailing housing opportunities for persons with disabilities. Alternatively, such facilities are built in less desirable settings to avoid community opposition.

3. The Department of Justice's Authority under CRIPA is Limited

The Civil Rights of Institutionalized Persons Act (CRIPA) protects the rights of institutionalized people. Under CRIPA, the Department of Justice (DOJ) may initiate a civil action where there is reasonable cause to believe that a state is engaged in a pattern or practice of subjecting institutionalized individuals to conditions that deprive them of the rights secured by the United State Constitution or Federal laws.[16]

CRIPA only authorizes investigation of institutions where there are patterns or practices of violations of rights; thus DOJ has no jurisdiction to investigate individual Olmstead complaints under CRIPA.

The DOJ's ability to conduct CRIPA investigations is dependent on the cooperation of the jurisdiction being investigated; in cases where access is denied, the DOJ must initiate costly and time-consuming litigation.

CRIPA does not authorize the DOJ to investigate privately-run institutions; therefore, the individual does not have the same remedies available.

CRIPA does not authorize DOJ to follow individuals who have been deinstitutionalized as a result of DOJ intervention into the community to ensure that they are safe and receiving services that are appropriate to meet their needs.

Federal Barriers Relating to Employment

1. Workforce Development System

There is insufficient capacity of the workforce development system to provide meaningful opportunities to people with disabilities, including people with significant disabilities and high support needs who are transitioning to the community from institutional settings or are at risk of segregation. These services, while intended for all people, have not always been inclusive of or welcoming to people with disabilities. Furthermore, because people with disabilities have not been a part of the workforce system, there has been little conceptual framework on the part of those working within that system on how to provide effective services. This has created multiple access issues for people with disabilities, especially in relation to physical accessibility, customer relations, knowledge about promising practices, provision of accommodations, and effective strategies and services.[17]

Further, there are not enough customized employment opportunities available to assist people with disabilities in developing a viable work situation. Customized employment is intended to match the unique strengths, abilities, and interests of persons with disabilities with the specific needs of employers. This is another symptom of federal policies that do not go far enough to support integrated employment opportunities.

2. Entrepreneurship

Entrepreneurship is a critical next step in fully integrating persons with disabilities into the community. According to the U.S. Department of Labor, there are a broad range of obstacles, both within and outside the federal government confronting people with disabilities who are interested in self-employment and small business ownership. These obstacles include: lack of access to capital; lack of information on business planning; and federal program policies that actually discourage entrepreneurship. Coordination across multiple public and private initiatives is critical to creating real entrepreneurial opportunities.

3. One-Stop Center Employment Services

One-Stop Center employment services have not focused on the unique needs of persons with mental illness. This is an issue not only for persons with disabilities, but also for mental health providers who are not aware of the information available through local employment services offices or the new One-Stop Centers. This has, in part, resulted in a 70% to 85% national unemployment rate for persons with mental illness.[18]

Endnotes

[1] *Delivering on the Promise,* U.S. Department of Justice, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[2] Ibid.

[3] Ibid.

[4] *The Social Security Handbook*, Social Security Administration, Section 100.Purposes of Social Security.

[5] *Delivering on the Promise,* U.S. Department of Health and Human Services Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[6] The Kaiser Commission on Medicaid and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book", page 169.

[7] *Delivering on the Promise,* U.S. Department of Health and Human Services Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[8] *Interim Report to The President,* The President's New Freedom Commission on Mental Health, October 29, 2002, page 4.

[9] *Interim Report to The President*, page 12.

[10] *Interim Report to The President,* page 13.

[11] *Delivering on the Promise*, U.S. Department of Health and Human Services Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[12] *Delivering on the Promise*, U.S. Department of Housing and Urban Development, Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[13] *Delivering on the Promise*, U.S. Department of Transportation Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[14] Ibid.

[15]*Delivering on the Promise,* U.S. Department of Justice, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[16] *Delivering on the Promise*, U.S. Department of Justice, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[17] *Delivering on the Promise*, U.S. Department of Labor, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[18] Ibid.

I. 300% SSI Analysis and Worksheet

Frank O'Bannon, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

John Hamilton, Secretary

"People helping people help themselves"

MEMORANDUM

TO:	Governor's Commission on Home and Community-Based Services
FROM:	Evelyn Murphy, Director, Long Term Care /s/
RE:	Report on the fiscal impact of 300% SSI to Aged & Disabled Waiver program
DATE:	May 1, 2003
CC:	John Hamilton, Melanie Bella, Steve Cook, Doug Beebe, Andrew Stoner

Attached is the revised fiscal impact report requested by the Commission. The report explains a number of policy issues raised by the Commission, including spenddown, cost-effectiveness of waivers, and the impact of the income standard for Aged, Blind and Disabled Medicaid applicants. The following provides a summary of the revisions.

Clarification of application of 300% SSI
The 300% SSI income standard operates as an income cap. Therefore, individuals with income above 300% SSI have one of the following options: (1) not eligible for services because they could not afford the spenddown; or (2) eligible with a spenddown calculated on the basis of the 100% SSI standard. Of the 257 individual on the aged and disabled waiver with spenddown who were identified in the analysis, only 5 individual have income above the 300% SSI standard. (Their monthly income level was estimated by adding their spenddown amount and the 100% SSI standard of $552). Their monthly spenddown ranged between $1,215-$1,490. These individuals may opt to be on spenddown based on the 100% SSI standard if they have high medical expenses.

Immediate impact on Medicaid program
The initial analysis understated the immediate additional costs to the Medicaid program by applying the average additional Medicaid (waiver & medical) costs less CHOICE costs to all 257 individuals on the Aged & Disabled waiver on spenddown. The CHOICE reduction must be applied only to the 75 individuals for whom CHOICE paid the spenddown. The difference in additional Medicaid costs is as follows:

- Waiver and medical costs for 182 non-CHOICE A&D waiver recipients = $7,554 (state $)
- Waiver and medical costs for 75 A&D waiver recipients receiving CHOICE = $6,071

Impact on nursing facility reimbursement
In order for savings to accrue in the nursing facility system, there must be a resulting change in the mix of nursing facility residents as well as a change in resident days as follows:

- *The average case mix index for Medicaid residents in the nursing facility should increase*. This may result from a number of changes including but not limited to, individuals with low needs leaving the facility and receiving services in the community, low needs individuals who opt to stay in the community instead of entering the facility, other ongoing changes in nursing facility case mix. Note that changes in individual facility case mix index occur frequently (either upward or downward). Such changes are transmitted quarterly and the appropriate rate adjustment occurs on a quarterly basis. The analysis assumes that availability of community services for individuals with higher income (i.e., 300% SSI) will result in more lower needs residents leaving the facility and more lower needs residents choosing to stay in the community. This will leave mostly higher needs patients in the facility causing an increase the overall average case mix index resulting in an increased in the average daily rate for nursing facilities.

- *The total number of patient days should decrease.* The decrease in nursing facility days should reach a point at which, overall, total reimbursement for nursing facilities would decrease despite the increase in daily rate.

- In addition, the original analysis did not take into account the waiver of medical costs of individuals who choose to leave the facility and who must be served in the community.

It is difficult to estimate the length of time it will take for this change in nursing facility mix to occur even if the 300% SSI income level is adopted. Other factors that will affect this change include provider capacity to serve the increasing number of individuals in the community, availability of other community and social supports for individuals (e.g., housing, family), etc.. This change will be gradual and will likely not occur for a couple of years.

Overall fiscal impact
Overall, it is expected that the above revisions will result in an increase in the immediate total additional costs for individuals on the aged and disabled waiver, from the originally estimated $2.4 million (state $) to $2.7 million (state $) annually. It is also anticipated that there needs to be a more significant change in nursing facility resident mix as well as reduction in patient days to counter act the increase expenditures in community services which would not occur for some time. The longer the change takes the longer the State must incur the additional costs for waiver recipients. (See revised Appendix D, Tables 1 & 2).

As with the original report, this revised report does not provide any conclusions as to whether the State should adopt the 300% SSI standard for Aged, Blind and Disabled waiver recipients at this time. This decision needs to be made in the context of the overall Medicaid budget and other program changes that may be proposed.

REPORT TO THE GOVERNOR'S COMMISSION ON HOME AND COMMUNITY BASED SERVICES

ESTIMATING THE FISCAL IMPACT OF INCREASING INDIANA'S INCOME ELIGIBILITY STANDARD FOR THE MEDICAID AGED, BLIND AND DISABLED (A&D) WAIVER TO 300% OF THE SSI AMOUNT

May 1, 2003

ESTIMATING THE FISCAL IMPACT OF INCREASING INDIANA'S INCOME ELIGIBILITY STANDARD FOR THE MEDICAID AGED, BLIND AND DISABLED (A&D) WAIVER TO 300% OF THE SSI AMOUNT

Table of Contents

ESTIMATING THE FISCAL IMPACT OF INCREASING INDIANA'S INCOME ELIGIBILITY STANDARD FOR THE MEDICAID AGED AND DISABLED (A&D) WAIVER TO 300% OF THE SSI AMOUNT

I. INTRODUCTION

This report is in response to the recommendation by the Governor's Commission on Home and Community-Based Services (the Commission) to evaluate the fiscal impact of increasing the income standard for the Medicaid Aged & Disabled (A& D) Waiver to 300% of Social Security Income (SSI). The Commission requested consideration of specific factors that would influence the fiscal impact. The factors include: Medicaid spenddown and patient liability; use of Indiana's CHOICE Program funds; Medicaid waiver program utilization; cost-effectiveness of Medicaid waiver services; and impact of the proposed change on the nursing facility case mix reimbursement system. The Commission also requested a summary of other state Medicaid waiver income criteria and an explanation of the impact on resource and asset eligibility requirements.

II. POLICIES & PROGRAM SUMMARY

1. EXPLANATION OF THE RELATIONSHIP AND EFFECT OF ADOPTING 300% SSI ON THE MEDICAID RESOURCES AND ASSETS REQUIREMENTS FOR ELIGIBILITY

There is no relationship between the income standard and the asset/resource standard for Medicaid financial eligibility purposes. These are two distinct eligibility requirements and applicants must meet both income and asset/resource standards to meet the financial eligibility requirements for Medicaid.

Resources (commonly referred to as "assets") are defined by Medicaid rule as "real or personal property owned by the applicant or recipient and his spouse or parent(s)" that are available to the individual applicant or recipient.[1] It includes for example, financial instruments convertible to cash like stocks and bonds, and current market value of real estate. The resource/asset limit for Medicaid eligibility is $1,500 (single)/$2,250 (couple). Where the spousal impoverishment protection is available, the community spouse's resource limit is between $17,856 (min) and $89,280 (maximum). Spousal impoverishment protections apply to applicants of nursing facility services and the Medicaid Assisted Living waiver. In addition, on November 14, 2002 the OMPP requested approval from the Centers for Medicare and Medicaid Services (CMS) to extend the spousal impoverishment protection to Medicaid Aged & Disabled Waiver applicants. The OMPP is awaiting CMS's approval to this waiver amendment.

[1] 405 IAC 2-3-14.

Under Medicaid rules, the income standard for the Medicaid Aged, Blind and Disabled populations is the SSI standard of $552 (single) or $829 (couple).[2] Medicaid income standards are also sometimes characterized by percentage of poverty level as follows:

- For Federal Fiscal Year (FFY) 2003, 100% SSI monthly income standard is $552 (single)/$829 (couple).
- For FFY 2003, 100% Federal Poverty Level (FPL) is reported annually as $8,980 (single) and $12,120 (couple). This equates to monthly standards of about $748 (single)/$1,010(couple).
- Thus, the Medicaid income standard of $552 can be characterized in federal poverty level terms as equivalent to about 74% of FPL.
- The 300% SSI monthly income standard = $1,656.

Thus, the current monthly income standard for the Aged, Blind and Disabled populations is $552, which is equivalent to 100% SSI or 74% FPL.

2. POLICY DESCRIPTION OF MEDICAID SPENDDOWN

Indiana Medicaid rule states that "any otherwise eligible [Aged, Blind or Disabled] applicant or recipient whose countable income exceeds the applicable income limit . . .is eligible for medical assistance for that part of any month after his or her incurred medical expenses equal his or her excess income.[3]" The rule further goes on to say that the individual must provide to the county "for each month in which he or she requests medical assistance, documentary verification of his or her incurred medical expenses for which he or she is currently liable."

Medicaid eligibility is determined monthly (referred to as member months). Therefore, in any month during which the recipient's income exceeds the income limit, the recipient goes on "spenddown." Generally, there is little variability in spenddown for a recipient from month to month, so in most cases, the recipient must incur the same amount of excess income on medical expenses to meet his/her spenddown from month to month. An individual becomes eligible only once s(he) has incurred medical expenses equal to his/her spenddown amount. This can occur any day in a given month. Once the individual meets the spenddown amount, the Medicaid program will then begin paying for covered services.

Example: On March 1 Anne has income of $600, which exceeds the monthly income standard of $552 by $48 (i.e., $600-$552=$48). Anne has to incur medical expenses totaling $48 before Medicaid will begin paying for covered services.

Scenario #1: Anne goes to the ABC pharmacy on March 3rd and fills 3 prescriptions totaling $100. Anne has to take the receipt to her county caseworker

[2] 405 IAC 2-3-18(b).
[3] 405 IAC 2-3-10.

to show that she has in fact incurred medical expenses. On March 3rd, the day Anne met her spenddown, Medicaid will then pay $52 to the pharmacy (i.e., $100-$48 = $52).

Scenario #2: Anne has a nurse visit on March 3 to check her blood pressure, and she is charged $30 for the visit. Then on March 4th she goes to the pharmacy to pick up her prescription and is charged $100. On March 3, no Medicaid payment is made for the nurse visit since Anne still has $18 in spenddown left to meet (i.e., $48-$30=$18). But on March 4th, she meets her spenddown and Medicaid will pay the pharmacy the difference ($100-$18=$82).

3. IMPACT OF INCOME STANDARD ON ELIGIBILITY FOR MEDICAID WAIVER VS. NURSING FACILITY SERVICES FOR THE AGED, BLIND AND DISABLED POPULATIONS.

The policy question when dealing with the income standard for the Aged, Blind and Disabled populations who reside in the community is how much *reasonably* an individual needs on a monthly basis to be able to live in a community setting within the limits established for the Medicaid program by federal law or regulation. This helps determine the level at which the income standard should be established, taking into account the fiscal and program implications. The income standard can be set anywhere from some percent of the federal poverty level (FPL) up to 300% SSI (i.e.$1,656), which is the highest income standard allowable for the Medicaid Aged, Blind and Disabled populations. Thirty-four (34) states have adopted 300% of SSI as the income standard for the Medicaid Aged, Blind and Disabled population; four (4) an income standard between 100% and 300% of SSI.[4] Indiana is one of the few states that has not adopted this standard.

By recommending the "300% SSI" standard it may be inferred that the Governor's Commission on Home & Community-Based Services (hereafter the "Commission") believes that an individual needs at least around $1,656 on a monthly basis to be able remain at home.

3.1 Impact of Medicaid income standard for institutional vs. community services

The income standard for the Medicaid Aged, Blind and Disabled populations is the same whether the individual resides in the community or in the nursing facility. So comparing the income standard in the community to nursing facility is only meaningful to the extent that it raises the question of how much income an individual can keep without losing eligibility for Medicaid in one setting compared to the other.

There is, however, a significant difference in how income impacts services. An individual in a nursing facility has all of his/her needs met, including food,

[4] State Eligibility Summaries for Selected Aged, Blind and Disabled Groups. (See Appendix E)

shelter, and medical care. As such the only income the individual really needs is the personal needs allowance (currently at $52); any excess income (s)he has is applied to the cost of his/her care. The individual remains eligible for Medicaid and pays all excess income, called "patient liability," to the nursing facility. He/she does not lose Medicaid eligibility.

In comparison, the current income standard of $552 for persons who live in the community suggests that the individual only needs $552 to cover all expenses except medical (including food, clothing and shelter). Hence, any income over and above $552 must be spent-down (i.e., as medical expenses) before the individual becomes eligible for the Medicaid program. It is this scenario that raises the policy question stated above and that creates a bias in favor of nursing facility services.

The following two sections provide examples of how the Medicaid income standard, though the same for the nursing facility or for the Medicaid Aged and Disabled Waiver populations, significantly impacts eligibility determination for nursing facility vs. waiver services. Please note that income is treated differently at two levels; first, there is treatment of income for regular eligibility, and second there is post-eligibility income treatment. The examples below attempt to illustrate both. Please note that nothing in these examples address resource (asset) eligibility or income deductions or exclusions. These examples are purely intended to establish a common ground in understanding the income standard and its application for community (Medicaid Waiver) vs. institutional (nursing facility) applicants for Medicaid services.

3.1.1 Nursing facility eligibility

The regular Medicaid eligibility standard for a nursing facility applicant is the same as for the Medicaid Aged & Disabled Waiver applicant. The amount is equivalent to the SSI standard of $552/month. In determining *regular eligibility* for the nursing facility applicant, we look to see if the individual's medical expenses exceed the difference between the individual's income and $552; if so the individual is eligible.[5] So if the monthly income is $2000, then the calculation for *regular eligibility* is as follows:

$2,000-$552=$1,448 (if medical expenses exceed $1,448 monthly, the individual is eligible.

Once the individual enters the nursing home, even as private pay for a couple of months, the individual's medical expenses very quickly will exceed the $1,448. Assuming a cost of $100/day (as an example), the monthly cost of nursing home placement is $3,000 ($100 x 30 days). Note that most individuals enter the nursing home before Medicaid eligibility is determined, so in this example, it can be assumed that their medical expenses are equivalent to the estimated total

[5] 405 IAC 2-3-17 and 405 IAC 2-13-18(b).

nursing facility charge of about $3,000/month, and eligibility can be assumed at the beginning of the month.

During *post-eligibility*, the same individual above would pay all his/her income less personal needs allowance (i.e., $2000 - $52 PNA = $1,948) as patient liability to the nursing facility, and Medicaid pays the remainder due.[6] The individual continues to remain eligible for Medicaid.

3.1.2 Medicaid Waiver Recipient Eligibility (applicable to all Aged, Blind and Disabled aid categories who seek NF-level waiver services)

The income standard is the monthly SSI standard of $552. For *regular eligibility*, assuming the same monthly income of $2,000, this individual would not be eligible for Medicaid since:

$2,000 - $552 = $1448. The individual would have to spenddown $1,448 before meeting the Medicaid income eligibility threshhold.[7]

Each month thereafter (i.e., *post-eligibility*) this calculation will be made and if the individual has excess income over $552, the individual would have to spenddown the excess income. In determining whether the individual has met the spenddown, we would only look at *incurred medical expenses*; so the inference is that the individual would be able to live off of $552 each month for rent, food, shelter etc.

Based on the income standard alone, it is much more affordable for the individual to enter a nursing facility as Medicaid eligibility occurs much sooner.

4. DESCRIPTION OF HOW MEDICAID 1915C WAIVER PROGRAM COST-NEUTRALITY IS DETERMINED AND ASSURED

In order to be approved, federal Medicaid regulation requires, all Medicaid home and community-based (1915c) waivers to be cost-neutral. In other words, the average per person costs for the waiver cannot exceed the average per person costs in the equivalent institutional setting. The cost-effectiveness calculation is based on claims paid according to dates of service for each waiver year. For each waiver program, a State must provide a report (CMS-372) to CMS twice annually (based on waiver year). The initial report is due 6 months after the close of the waiver year. Since the initial report does not provide sufficient time to account for claims lag (especially since the report is by paid date), a second report, called the lag report, is due one year after the initial report (i.e., 18 months after the close of the waiver year).

---

[6] 405 IAC 2-3-21.

[7] 405 IAC 2-3-10 spenddown.

The cost-neutrality formula is as follows:

$$D + D' <= G + G'$$

D, the average annual per capita waiver services expenditures =

$$\frac{\text{Total expenditures for approved waiver services}}{\text{Total unduplicated waiver recipients}}$$

D', the average annual per capita expenditures for all other Medicaid services provided to the waiver recipient =

$$\frac{\text{Total expenditures for medical services for waiver recipients (i.e., Services provided under the state plan such as pharmacy, acute care, home health)}}{\text{Total unduplicated waiver recipients}}$$

G, the average annual per capita institutional (ICF/MR or NF) services expenditures (excluding any patient liability) =

$$\frac{\text{Total expenditures for institutional services (ICF/MR or NF)}}{\text{Total unduplicated institutional recipients}}$$

G', the average annual per capita non-institutional (ICF/MR or NF) services expenditures for individuals in institutions =

$$\frac{\text{Total expenditures for non-institutional services (ICF/MR or NF) for the institutionalized recipients (e.g., pharmacy, acute care, non-routine DME)}}{\text{Total unduplicated institutional recipients}}$$

The cost-neutrality formula for SFY 2002 for Indiana Medicaid Aged and Disabled Waiver recipients is summarized in the chart below. These figures will be used as the baseline for determining the fiscal impact of raising the income standard to 300% SSI.

Per capita costs of Aged & Disabled Waiver recipient (excluding spenddown)	Per capita costs of nursing facility resident (excluding patient liability)
D + D' $7,583 + $12,297 = $19,880 $7,554 (state only $)	G + G' $20,727 + $ 5,136 = $25,863 $9,828 (state only $)

CAVEAT: Please note that these costs are based on SFY 2002 incurred data for the initial CMS372 report. These costs will increase as a result of claims lag as well as addition of new services to the Aged & Disabled waiver that occurred during the course of CY2002.

III. FISCAL IMPACT OF 300% SSI INCOME STANDARD

1. SUMMARY

The following is a general summary of how the fiscal impact of increasing the monthly income standard from the 100% SSI standard of $552 to the 300% SSI standard of $1,656 for the Medicaid Aged & Disabled Waiver applicants was determined.

(i) Identify the number of individuals currently receiving services under the Medicaid Aged & Disabled Waiver, their spenddown amount and the number of months during which they were on spenddown. This is important because increasing the income standard would eliminate excess income, thereby no longer requiring individuals to meet their spenddown. When such individuals no longer have a spenddown, Medicaid is responsible to pay for services.

(ii) Some Medicaid Aged & Disabled Waiver recipients on spenddown have all or a portion of their spenddown met with CHOICE funds. This is necessary in determining the additional State expenditures that would result from individuals no longer having a spenddown.

(iii) Determine the number of CHOICE clients who would become eligible for waiver services as a result of this change. CHOICE generally serves a group of individuals at higher income levels, who may also have limitations in 3 ADLs, and meet the Medicaid asset requirements. These individuals would become eligible for the waiver at the 300% SSI income standard.

(iv) Determine the impact that the income standard has on utilization of Medicaid State Plan services. This is an important consideration, as federal regulations require that Medicaid State Plan services be made available to all Medicaid waiver recipients.

(v) Determine the short and long-term impact of the increase in eligibility on utilization of nursing facility services. As more individuals are able to remain in the community, it is anticipated that the mix of nursing facility residents will eventually become more acute, which would likely result in an increase in the nursing facility's daily rate, and overall decrease in

patient days, and therefore, an overall decrease in nursing facility spending.

2. MEDICAID A&D WAIVER RECIPIENTS ON MEDICAID SPENDDOWN & CHOICE CLIENTS

2.1 Medicaid Spenddown amounts and number of months on spenddown

The following data is based on State Fiscal Year (SFY) 2002 paid claims data

- A total of 257 Medicaid Aged & Disabled Waiver recipients had a spenddown.
- The total spenddown amount for all 257 individuals was about $1.1 million.
- Their spenddown amount ranged from a low of $4 per month to $1,490 per month.
- The spenddown amount for each individual was not variable from month-to-month.
- The range of months during which these individuals were on spenddown was from 1 month to 12 months. The 257 recipients were on spenddown for a total of 1,942 member months. The mean member month during which an A&D waiver recipient was on spenddown in SFY 2002 was 7 months.

2.2 Medicaid Spenddown recipients & CHOICE

Increasing the income standard for the Medicaid Aged & Disabled waiver to 300% SSI has the following results: (1) current Aged & Disabled waiver recipients no longer have a spenddown; (2) some CHOICE clients who are otherwise eligible for the Medicaid waiver but for the current income standard would become eligible; and (3) Medicaid expenditures will increase due to the number of CHOICE clients moving to the Medicaid waiver and waiver recipients coming off spenddown.

2.2.1 Additional State expenditures resulting from removal of current Medicaid Aged & Disabled waiver recipients from spenddown

Of the 257 individuals on Medicaid spenddown, only 75 were receiving CHOICE funded services during the same period. Although specific data is not readily available to reach a conclusion, it can be assumed that CHOICE funds were utilized to pay for services to meet the individual's spenddown, if the services funded by CHOICE qualify as medical services for purposes of meeting the spenddown.

- The total spenddown amount for waiver recipients was $1.1 million.
- The amount of CHOICE funds paid for those 75 individuals was $196,026. The median CHOICE payment for the 75 individuals is $1,483.

- Assuming that all $196,026 was to assist the individual in meeting the spenddown, then CHOICE funds were used to meet part or all of the spenddown for 29% of all individuals on the Medicaid Aged &Disabled waiver who had a spenddown (i.e. 75/257).
- Furthermore, CHOICE funds were used to meet 18% ($196,026/$1.1million) of the total spenddown for all A&D waiver recipients.

During the time before individuals meet their spenddown, Medicaid does not cover the costs of waiver services or state plan services. Therefore the added cost to the Medicaid program is as follows:

Per capita State expenditures for waiver recipients less CHOICE funds currently spent on a Medicaid waiver recipient on spenddown (using the median)

$7,554 - $1,483 = $6, 071 (state $)

Total estimated additional State expenditures for individuals who were on CHOICE who would become eligible by virtue of the increase in income standard to 300% SSI resulting in zero spenddown for these individuals:

$6,071 x 75 = $455,325 (state $)

Total estimated additional State expenditures for all individuals who were not on CHOICE and would become eligible by virtue of the increase in income standard to 300% SSI resulting in zero spenddown for these individuals:

$7,554 x (257-75) = $1,374,828 (state $)

Total estimated additional State expenditures for all individuals who would become eligible by virtue of the increase in income standard to 300% SSI resulting in zero spenddown for these individuals:

$455,325 + $1,374,828= $1.83 million (state dollars)

2.2.2 Additional state expenditures from CHOICE clients becoming eligible for the Medicaid Aged & Disabled waiver

The number of CHOICE clients who would become eligible for the waiver is based on the total number of CHOICE clients with limitations in 3 or more activities of daily living (ADLs) whose income is at or above the 300% SSI standard (i.e., $1,656 monthly).

There are approximately 983 CHOICE clients with incomes at about 300% of SSI. The annualized CHOICE expenditures for these individuals is $4.7 million. Representation from the Indiana Association of Area Agencies on Aging states that 68% of the individuals on CHOICE with 3 ADLS and high-income levels

would be ineligible for Medicaid because their resources would exceed the Medicaid requirements.[8] The additional state costs resulting from CHOICE clients becoming eligible for the Medicaid Aged &Disabled waiver is as follows.

- Total number of CHOICE clients with 3 ADLs with income equivalent to 300% SSI is 314 (i.e., 32% x 983).
- Total annualized CHOICE expenditures for these clients is about $1.5 million {i.e., ($4.7 million/983) x 314}.
- Additional state expenditures for 314 individuals moving from CHOICE to the waiver less CHOICE expenditures is:

($7,554 x 314) - $1.5 million = $0.9 million (state dollars)

The increase in state expenditures is attributable to making all Medicaid State Plan services available to this population.

2.2.3 Estimated immediate costs, annually, to the Medicaid program of increasing the income standard to 300% SSI

The immediate costs to the Medicaid program is as follows:

$1.83 million + $0.9 million = $2.7 million (state dollars)

3. SHORT AND LONG TERM IMPACT ON CASE MIX SYSTEM AND NURSING FACILITY REIMBURSEMENT

In order to estimate the fiscal impact of increasing the income eligibility standard for the Aged and Disabled (A&D) Waiver to 300% of the SSI amount, it was assumed that some recipients who would have been admitted to a nursing facility due to their income, would instead choose to obtain services in the community under the Medicaid A&D waiver, and would remain at home. It was also assumed that certain individuals currently in nursing facilities might be able to return home or in other community settings due to the increased income standard. Based on ad hoc analysis of Indiana's nursing facility MDS (minimum data set) data, it was also assumed that recipients that would have thus been diverted from being admitted to a nursing facility or who would return to the community would classify in the lowest levels of the resident classification system (RUG-III), which are called "PA1" and "PB1." This is actually a very conservative approach, since a number of residents in higher levels may also be safely and cost-effectively served in the community if given the choice.

A model was developed to estimate the fiscal impact on Medicaid nursing facility expenditures based on the change in the overall case mix of the nursing facility population, and a decrease of 200, 500, 1000 and 1500 recipients from the nursing

[8] E-mail from Melissa Durr, Executive Director, IAAA dated February 12, 2003.

facility statewide. The Medicaid nursing facility budget would be impacted in two ways. First, since Indiana Medicaid reimburses nursing facilities under a "case mix" methodology,[9] by removing residents in the lowest levels of the RUG-III system (all other things alike), the average nursing facility case mix index will increase, thus appropriately increasing the average Medicaid daily rate per remaining nursing facility residents. This is summarized in the table below.

1. Estimated Increase in Nursing Facility Expenditures Due to Increasing Case Mix				
Reduction in low needs nursing facility residents	**200**	**500**	**1000**	**1500**
Avg. Current Direct Care Medicaid Rate	$51.25	$51.25	$51.25	$51.25
Increase in rate due to higher needs resident mix	+$.05	+$.12	+$.25	+$.39
Adjusted Medicaid Direct Care Rate	$51.30	$51.37	$51.50	$51.64
Estimated Annual Medicaid Days of Remaining Nursing Facility Recipients	9,981,600	9,954,000	9,908,000	9,862,000
Total Estimated Increase in Medicaid NF Expenditures	$483,720	$1,227,786	$2,519,227	$3,878,345
(State $)	$183,814	$466,559	$957,306	$1,473,771

Second, by reducing the overall number of residents from nursing facility admission, Medicaid will not incur nursing facility expenditures for those recipients. This is summarized in the table below.

2. Estimated Decrease in Nursing Facility Expenditures Due to Fewer Nursing Facility Recipients				
Reduction in nursing facility residents	**200**	**500**	**1000**	**1500**
Average Medicaid Rate (excluding client liability amount)	$79.70	$79.70	$79.70	$79.70
Total Estimated Annual Decrease in Medicaid	($5,817,735)	($14,544,338)	($29,088,675)	($43,633,013)
Nursing Facility Expenditures (State $)	($2,210,739)	($5,530,648)	($11,053,697)	($16,580,545)

[9] Case Mix reimbursement ties payment to the facility based on the level of resource needs of their residents. Higher needs or acuity residents generate higher reimbursement, and vice versa. The levels of case mix are based on individual resident assessment data that all facilities are required to submit called the "Minimum Data Set," or MDS.

Net savings that can be achieved by serving low needs individuals in the community instead of in the nursing facility as show on the table below.

3. Estimated Savings in Nursing Facility Expenditures				
Reduction in low needs nursing facility residents	**200**	**500**	**1,000**	**1,500**
Total annual estimated savings (state $)	($2,026,925)	($5,064,089)	($10,096,391)	($15,106,774)

The result of this analysis is as follows:

- The average Medicaid per person nursing facility reimbursement rate will *increase* as more elderly consumers are given the opportunity to receive services in the community. This increase in rates is appropriate, since nursing facilities would be serving persons with greater care needs.
- Total annual Medicaid nursing facility expenditures will, however, *decrease* over time, assuming fewer people are served in nursing facilities. This assumes actual reduction in total residents in the facility.
- Per person Medicaid A& D Waiver costs would not be expected to increase since existing medical criteria already requires the Waiver to serve persons with nursing facility level of care needs.
- Total Medicaid A & D Waiver expenditures will thus increase proportionately with the number of diverted persons added.

As a result, total annual Medicaid expenditures can therefore be expected to *decrease* by the difference between the annual nursing facility savings and the additional waiver expenditures incurred by the diverted consumers.

4. ESTIMATED COST (SAVINGS) TO THE MEDICAID PROGRAM TAKING INTO ACCOUNT THE COSTS OF SERVING MORE INDIVIDUALS IN THE COMMUNITY AT THE 300% INCOME STANDARD.

Individuals who are no longer served in the nursing facility due to nursing facility diversions or conversions must be served on the Aged & Disabled waiver. Therefore, the decrease in nursing facility expenditures must be balanced against a corresponding increase in individuals served on the Aged & Disabled waiver of $7,554 (state dollars) per person served on the waiver. The result is that there needs to be a significant change in nursing facility patient mix and total number of residents served in order to for the increase to 300% SSI to be cost neutral to the State. (See Appendix D). As a result, it is expected that the costs to the Medicaid program of increasing the income standard to 300% SSI would continue for some time.

5. CONCLUSION

The overall impact of increasing the income standard for Aged, Blind and Disabled populations on the Aged & Disabled Waiver is as follows:

- By increasing the income standard, individuals currently on the Aged & Disabled waiver with a spenddown will come off spenddown resulting in an *increase* in Medicaid expenditures for Aged & Disabled waiver recipients.
- Furthermore, Medicaid expenditures will *increase* due to eligible CHOICE recipients who would become eligible and be served on the Aged & Disabled waiver.
- The average Medicaid per person nursing facility reimbursement rate will *increase* as more elderly consumers are given the opportunity to receive services in the community. This increase in rates would be appropriate, assuming nursing facilities would be serving persons with greater care needs.
- Total annual Medicaid nursing facility expenditures will, however, *decrease* significantly over time, assuming fewer people receive services in nursing facilities. However this would also result in an *increase* in expenditures on the Aged & Disabled waiver as more individuals who otherwise would be in a nursing facility would be served on the waiver.
- **The long-term net result to the Medicaid program depends on the change in nursing facility patient mix and the reduction of total number of patients and overall patient days in the nursing facility**.

However, because the reduction in number of residents and patient days in nursing facilities, and CMI mix would only occur in the long term, **the immediate impact is an increase of $2.7 million (state dollars) annually** in Medicaid expenditures from the proposed change in income standard. Long-term, savings will accrue proportionally with the number of individuals who remain in the community instead of going into the nursing facility.

The following factors will also influence the actual fiscal costs/(savings) throughout this document:

- Currently the Aged & Disabled wait list is less than 100 individuals statewide. It is expected that without an increase in the total number of funded slots on the Aged and Disabled Waiver, there will be a significant increase in the waiting list since more individuals would apply due to the higher income standard.
- This fiscal analysis is based on SFY2002 dollars, number of recipients and utilization. The Medicaid budget projects a 2.5% increase (state and federal $) in overall nursing facility expenditures from SFY2003 to SFY2004. In addition, because a number of new services were added to the Aged Disabled

waiver in the last year, there is no meaningful historical information to estimate the impact on overall waiver expenditures.

Table 1. IMMEDIATE IMPACT ON MEDICAID

1. Additional cost of current A&D waiver spenddown recipients	
Average Medicaid cost (waiver & medical)	$7,554
x Total number of recipients (not on CHOICE) off spendown	182
Equals	$1,374,828
PLUS	
Average Medicaid cost (waiver & medical)	$7,554
Less average CHOICE (spenddown) cost	$1,483
Equals	$6,071
x Total number of recipients on CHOICE off spendown	75
Equals	$455,325
Total additional costs	**$1,830,153**
2. Additional cost of CHOICE recipients to A&D waiver	
Average Medicaid cost (waiver & medical)	$7,554
x Number of CHOICE recipients to A&D waiver	314
Equals	$2,371,956
Less total CHOICE costs for these recipients	$1,498,747
Total additional costs	**$873,209**
3. Total Estimated Costs of 300% SSI	**$2,703,362**

Table 2. LONG TERM IMPACT ON NURSING FACILITY REIMBURSEMENT

	Number of Residents			
	200	500	1000	1500
A. IMPACT ON NURSING FACILITY REIMBURSEMENT				
Estimated *increase* in Medicaid expenditures due to increasing case mix	$183,814	$466,559	$957,306	$1,473,771
Plus Estimated (*decrease)* in annual nursing facility expenditures due to fewer nursing facility residents & decreased Medicaid days	($2,210,739)	($5,526,848)	($11,053,697)	($16,580,545)
Equals **Net costs or (savings)**	**($2,026,925)**	**($5,060,289)**	**($10,096,391)**	**($15,106,774)**
B. TOTAL COSTS OF SERVING FORMER NURSING FACILITY RESIDENTS ON WAIVER				
Number of recipients x Average Waiver & Medical Costs @ $7,554pp	**$1,510,800**	**$3,777,000**	**$7,554,000**	**$11,331,000**
C. OVERALL IMPACT OF INCREASE IN INCOME STANDARD TO 300% SSI				
Additional Medicaid costs for Waiver & Medical services for individuals of spendown and new eligibles (formerly on CHOICE)	$2,703,362	$2,703,362	$2,703,362	$2,703,362
Plus Additional Medicaid costs (Waiver & Medical) for former nursing facility recipients	$1,510,800	$3,777,000	$7,554,000	$11,331,000
Equals	$4,214,162	$6,480,362	$10,257,362	$14,034,362
Total costs (savings) in nursing facility reimbursement	($2,026,925)	($5,060,289)	($10,096,391)	($15,106,774)
Grand Total Estimated Costs or (Savings)	**$2,187,237**	**$1,420,073**	**$160,971**	**($1,072,412)**

J. References and Relevant Web Sites

References and Relevant Web Sites

Governor's Commission on Home and Community-Based Care – www.in.gov/fssa/community/

Indiana State Agencies and Programs

Addiction Services - http://www.in.gov/fssa/serviceaddict/index.html
Children's Assistance Programs - http://www.in.gov/fssa/children/index.html
Disability Resources - http://www.in.gov/ai/disability/index.html
Family Care Coordination - http://www.in.gov/isdh/programs/mch/fcc.htm
Governor's Planning Council for People with Disabilities - http://www.in.gov/gpcpd/
Hoosier Rx Program - http://www.in.gov/fssa/hoosierrx/index.html
Indiana Commission for Higher Education - http://www.che.state.in.us/
Indiana Department of Education - http://www.doe.state.in.us/
Indiana Department of Health - http://www.in.gov/isdh/index.htm
Indiana Department of Veterans Affairs - http://www.in.gov/veteran/
Indiana Department of Workforce Development - http://www.in.gov/dwd/
Indiana Family and Social Services Administration – http://www.in.gov/fssa/
Indiana Family Helpline - http://www.in.gov/isdh/programs/mch/ifh.htm
Indiana General Assembly - http://www.in.gov/legislative/legislators/
Indiana Housing Finance Authority - http://www.in.gov/ihfa/
Indiana Office of the Governor - http://www.in.gov/gov/
Indiana Office of Utility Consumer Counselor - http://www.in.gov/oucc/http://www.in.gov/oucc/
Indiana Medicaid Program - http://www.in.gov/fssa/servicedisabl/medicaid/index.html
Mental Health Services - http://www.in.gov/fssa/servicemental/index.html
Senior Health Insurance Information Program - http://www.in.gov/idoi/shiip/index.html
Temporary Assistance to Needy Families - http://www.in.gov/fssa/families/resources/index.html

Federal Agencies

Centers for Medicare and Medicaid Services – www.cms.hhs.gov/
Medicare Program Information - http://cms.hhs.gov/medicare/
Medicaid Program Information - http://cms.hhs.gov/medicaid/
State Children's Health Insurance Program - http://cms.hhs.gov/schip/
U.S. Department of Education - http://www.infoctr.edu/fwl/fedweb.exec.htm#doed
U.S. Department of Health and Human Services - http://www.infoctr.edu/fwl/fedweb.exec.htm#hhs
U.S. Department of Housing and Urban Development - http://www.infoctr.edu/fwl/fedweb.exec.htm#hud
U.S. Department of Labor - http://www.infoctr.edu/fwl/fedweb.exec.htm#labor
U.S. Department of Veteran Affairs - http://www.infoctr.edu/fwl/fedweb.exec.htm#va

Grant Opportunities

Robert Wood Johnson grant opportunity "Better Jobs, Better Care" – www.rwjf.org/newsEvents/mediaRelease.jsp?id=1035779539914
Real Choice Systems Change Grants for Community Living – www.cms.hhs.gov/newfreedom/default.asp.
Medicaid Infrastructure Grants – www.cms.hhs.gov/twwiia/default.asp.

References and Relevant Web Sites (Continued)

Reference Information

Indiana Long Term Care Facility Directory - http://www.in.gov/isdh/regsvcs/ltc/directory/index.htm
Indiana Nursing Home Report Card - http://www.in.gov/isdh/regsvcs/ltc/repcard/rptcrd1.htm
Indiana Family and Social Services Reports - http://www.in.gov/fssa/statistics/index.html
Indiana Services for Older Adults - http://www.in.gov/fssa/elderly/index.html
(Indiana) What to Do If You Lose Your Job - http://www.in.gov/dwd/jobseekers.shtm
List of Indiana human services assistance programs - http://www.in.gov/ai/social/programs.html
NPR Series on Housing (including nursing home transitions) – www.npr.org/news/specials/housingfirst/nprstories/020806.kansas/
HUD Draft Strategic Plan for FY 2003-2008 – www.hud.gov/initiatives/strategicplan/strategicfull.pdf
U.S.Department of Health and Human Services reference guide "Understanding Medicaid Home and Community Services: A Primer" – www.aspe.hhs.gov/daltcp/reports/primer.htm
Indiana workforce statistics - http://www.in.gov/dwd/inews/lmi.asp